FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE AUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean he mode of dying, such as heart failure, sthenia, etc. It means he disease, or compli-cations which caused

nditions, if any, hich gave rise to ove cause (a), tating the under-lying cause last.

Conditions contrib-uting to death but not related to the terminal disease condition given in (a).

2065

100M-12-62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

1

PLACE OF DEATH: WORCESTER (County); SOUTHBORO (City or Town)

(City or Town making this return)

Registered No. .....

No. CORDAVILLE ROAD St. ((If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME RICHARD GREEN HARWOOD
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. CORDAVILLE ROAD St. SOUTHBORO MASS
(Usual place of abode) (City or town and State)

Length of stay: In place of death 27 years ..... months ..... days. In place of residence 42 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY (Month) 11 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY 8, 1950, to JAN 11, 1964

I last saw him alive on JAN. 9, 1964, death is said to have occurred on the date stated above, at 10:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Arteriosclerotic Heart Disease	11 mo.
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Diabetes Mellitus	14 yrs

Was autopsy performed? no

What test confirmed diagnosis? clinical tests: ECG, etc.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signature) Timothy P. Stone, M. D.

TIMOTHY P STONE
(Print or Type Name)

(Address) MAIN ST, SOUTHBORO Date JAN 11 1964

6 Place of Burial or Cremation: MT AUBURN CREMATORY CAMBRIDGE (City or Town)

DATE OF ~~BURIAL~~ " JANUARY 13 1964

7 NAME OF FUNERAL DIRECTOR ROBERT K WADSWORTH

ADDRESS 108 LINCOLN ST. FRAMINGHAM

Received and filed Jan 13, 1964 19.....

Eleanor F. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
MALE	WHITE	MARRIED

11 If married, widowed, or divorced
HUSBAND of GRACE KNIGHT
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 AGE 77 Years 3 Months 20 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation LIVESTOCK COMMISSIONER
(Kind of work done during most of working life)

14 Industry or Business SELF EMPLOYED

15 Social Security No. 031 - 26 - 8263

16 BIRTHPLACE (City) (State or country) LITTLETON MASS

PARENTS

17 NAME OF FATHER HERBERT J HARWOOD

18 BIRTHPLACE OF FATHER (City) (State or country) LITTLETON MASS

19 MAIDEN NAME OF MOTHER EMELIE GREEN

20 BIRTHPLACE OF MOTHER (City) (State or country) LANCASTER MASS

21 Informant MRS GRACE K HARWOOD (WIFE)

(Address) CORDAVILLE RD SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sara C Tavoletti Asst T
(Signature of Agent of Board of Health or other)

(Official Designation)

Jan 13 1964
(Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

3

COPY OF CERTIFICATE OF DEATH

Registered No. 18 3

Westborough (City or Town making this return)

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bertha Alton Miller (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence, No. Turnpike Rd. St. Southboro, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death - years 8 months 14 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: January (Month) 21, (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 7, 1963, to Jan. 21, 1964

I last saw her alive on Jan. 21, 1964 death is said to have occurred on the date stated above, at 10.15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute pulmonary edema

Due To (b) Cardiac failure

Due To (c) Coronary insufficiency

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) Shyam Agrawal, M. D.

(Address) Westboro, Mass. Date 1/21 1964

6 Place of Burial or Cremation: Crystal Lake Cem. Gardner, Mass. (City or Town)

DATE OF BURIAL Jan. 24, 1964

7 NAME OF FUNERAL DIRECTOR John A. Mack

ADDRESS Gardner, Mass.

Received and filed February 10 1964

Anna F Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Cannot be learned
(Husband's name in full)

12 AGE ..... Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife - ret.
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Advocate Harbor (State or country) Nova Scotia

PARENTS

17 NAME OF FATHER: Charles E. Smith

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER: Elizabeth A. Spicer

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Nova Scotia

21 Informant: Westborough State Hospital Records

(Address) .....

A TRUE COPY

ATTEST: Anne A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED Jan. 29, 1964

50M-6-62-933404

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

7

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Westborough (City or Town) — Westborough (City or Town making this return)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eva Dunn (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Parkerville Rd. (Usual place of abode) St. Southborough, Mass. (City or town and State)

Length of stay: In place of death 7 years 8 months 8 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 1 (Month) (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 24, 1963, to Feb. 1, 1964, I last saw h... alive on Feb. 1, 1964, death is said to have occurred on the date stated above, at 2.25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Cerebral Arteriosclerosis — yrs

Was autopsy performed? No

What test confirmed diagnosis? Physical Exam

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Samuel Segal, M. D.

(Address) Westboro, Mass. Date Feb. 1 1964

6 Burial Com. Southboro Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 4, 1964

7 NAME OF FUNERAL DIRECTOR Carl Willson

ADDRESS Framingham, Mass.

Received and filed March 11, 1964

Rennes F Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Female	White	Widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Walter F. Dunn (Husband's name in full)

12 AGE 79 Years 1 Months 19 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Salem, Mass.

PARENTS

17 NAME OF FATHER John B. Cameron

18 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Sarah Crosby

20 BIRTHPLACE OF MOTHER (City) (State or country) Salem, Mass.

21 Informant Westborough State Hospital Records (Address)

A TRUE COPY
ATTEST: Irene A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED February 4, 1964

50M-6-62-93310M

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1959, requires Physicians to print or type name under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 2

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Woodland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: FLORA FLORENCE MAY MAHONEY (née NICHOLAS) Melrose
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) 2

(a) Residence, No. Woodland Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 9 months ....days. In place of residence ....years 9 months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: FEBRUARY 1, 1964
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JUNE 1, 1963, to FEBRUARY 1, 1964
I last saw her alive on JANUARY 28, 1964, death is said to have occurred on the date stated above, at 11:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	CARCINOMA, OVARY	11 mos
Due To (b)	—	
Due To (c)	—	
OTHER SIGNIFICANT CONDITIONS	—	

Was autopsy performed? no
What test confirmed diagnosis? examination, X-Rays.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify —

(Signed) Timothy P. Stone, M. D.
TIMOTHY P. STONE
(PRINT OR TYPE SIGNATURE)
(Address) Southboro, Mass. Date FEB 1, 1964

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 5, 64

7 NAME OF FUNERAL DIRECTOR Francis M. Wilson, Inc.
ADDRESS 28 College Ave. Somerville 44, Mass.

Received and filed February 5 1964
Mildred L. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ....
(or) WIFE of John J. Mahoney
(Give maiden name of wife in full)
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 8 Months 24 Days | If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Sales Lady
(Kind of work done during most of working life)

14 Industry or Business: Department store

15 Social Security No. 029 - 07 - 3625

16 BIRTHPLACE (City) (State or country) Ishpeming Michigan

PARENTS

17 NAME OF FATHER James E. Nicholas

18 BIRTHPLACE OF FATHER (City) Liverpool
(State or country) England

19 MAIDEN NAME OF MOTHER Eliza Webster

20 BIRTHPLACE OF MOTHER (City) Londenderry
(State or country) N.S., Canada

21 Informant Mrs. F. Anita Jordan
(Address) Woodland Rd., Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Anna Lina A Tarcaletta, Agent
(Signature of Agent of Board of Health or other)

(Official Designation)

July 3-1964
(Date of Issue of Permit)

100M-6-60-928145

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

6

BOSTON
(City or Town making this return)

Registered No. 01217

PLACE OF DEATH
1 OUT - OF - TOWN
SUFFOLK (County)
BOSTON (City or Town)

No. LEMUEL SHATTUCK HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME RUTH E. BENKOSKI (WARING)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. Marlboro Road St. Southboro
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 5 months days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 3 1964
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1963, to February 3, 1964
I last saw her alive on Feb. 3, 1964 death is said to have occurred on the date stated above, at 9:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Adenocarcinoma of Bowel
Due To
(b) Metastatic
Due To
(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Bruce C. Ferguson, M. D.
Bruce C. Ferguson, M. D.
(Print or Type Name)
(Address) 170 Morton St. JP Date 2/3 1964

6 Place of Burial or Cremation Rural Cemetery SOUTHBORO (City or Town) (MASS.)
DATE OF BURIAL FEB 7th 1964

7 NAME OF FUNERAL DIRECTOR Beyle Bros.
ADDRESS 1734 Union Ave Fram.

Received and filed FEB 7 1964 19
William J. Hennessey (Registrar)

A TRUE COPY ATTEST: Rec'd March 9, 1964

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Female	White	MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Victor M. Benkoski
(Husband's name in full)

12 AGE 44 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation Clerk, Typist
(Kind of work done during most of working life)

14 Industry or Business M.D.C. Office

15 Social Security No. 031-03-2146

16 BIRTHPLACE (City) Cambridge
(State or country) Mass

PARENTS

17 NAME OF FATHER Walter Waring

18 BIRTHPLACE OF FATHER (City) C.N.B.L.
(State or country) England

19 MAIDEN NAME OF MOTHER Edieth McGee

20 BIRTHPLACE OF MOTHER (City) Lowell
(State or country) Mass

21 Informant Mr. Victor M. Benkoski (Husband)
(Address) Marlboro Rd. Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
20455
(Official Designation)
2-5-64
(Date of Issue of Permit)

153.9
47
X71

100M-12-62-934553

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931848

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Southboro (City or Town making this return)

Registered No. 253 4

No. Metropolitan Water System St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Michael S. Bruce (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence. No. Cordaville Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 30 Min. days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 15, (Day) 1964 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Accidental Drowning

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 3PM Feb 15, 19 64

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Walter F. Mahoney, M. D.
(Print or Type Name)

(Address) Weston Date 15 Feb 1964

7 Rural Cemetery Southboro, Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Feb. 18, 19 64

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed February 20 19 64

Eleanor F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
M	White	Single

12 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH August 31, 1950

14 AGE 13 Years 5 Months 14 Days | If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Student
(Kind of work done during most of working life)

16 Industry or Business: Woodward Grammar Schoo

17 Social Security No. None

18 BIRTHPLACE (City) Lewiston
(State or country) Maine

PARENTS

19 NAME OF FATHER Robert D. Bruce

20 BIRTHPLACE OF FATHER (City) South Paris
(State or country) Maine

21 MAIDEN NAME OF MOTHER Marion Campbell

22 BIRTHPLACE OF MOTHER (City) Lewiston
(State or country) Maine

23 Informant (Address) Robert D. Bruce Cordaville Rd. Southboro Mas

I HEREBY CERTIFY that a satisfactory standard certificate of deat was filed with me BEFORE the burial or ~~transit~~ permit was issued:

Anna Sina A. Locatelli Agent
(Signature of Agent of Board of Health or other)

(Official Designation) 2/18/64 (Date of Issue of Permit)

MEDICAL

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Southboro (City or Town making this return)

Registered No. 253 5

No. Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Donald (Hicks) LeClear.
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Legeune St. Southboro Worcester St. Transient
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 2 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb (Month) 15 (Day) 64 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden Death Presumably
Coronary Sclerosis

5 Accident, suicide, or homicide (specify)

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? No Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Walter F. Mahoney, M. D.
(Print or Type Name)

(Address) Weston Mass Date Feb 15 19 64

7 Newton cemetery Newton, Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Feb. 19, 1964 19

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed February 21 19 64

A TRUE COPY ATTEST: Eleanor F. Burke (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
M	White	Divorced

12 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH Jan. 28, 1911

14 AGE 53 Years 11 Months 17 Days | If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation Ship Yard Worker
(Kind of work done during most of working life)

16 Industry or Business Boats

17 Social Security No.

18 BIRTHPLACE (City) Biddeford
(State or country) Maine

PARENTS

19 NAME OF FATHER Gifford LeClear

20 BIRTHPLACE OF FATHER (City) Rutherford
(State or country) N.J.

21 MAIDEN NAME OF MOTHER Helen Parker

22 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

23 Informant Mrs. Augustus Doty
(Address) 275 Horse Road Sudbury, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sue A. Doraletti, Agent
(Signature of Agent of Board of Health or other)

(Official Designation)

2-19-64
(Date of Issue of Permit)

MEDICAL

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-9-63-9363L8

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

11

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); Framingham Manor Nursing Home; No. 228 Concord St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Ida C. Gibson (Goward) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Breakneck Hill Rd. St. Southboro (City or town and State) (Usual place of abode)

Length of stay: In place of death 2 years.....months.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April 13, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Apr. 26 62 to April 13, 64, 19..... I last saw h.....alive on April 13, 64, 19....., death is said to have occurred on the date stated above, at 11:45a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Embolus to right popliteal artery — INTERVAL BETWEEN ONSET AND DEATH: 5Hrs.

Due To (b)

Due To (c) Generalized arteriosclerosis 10Yrs.

OTHER SIGNIFICANT CONDITIONS: Arteriosclerotic heart disease 2Yrs.

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Grace E. Tiffany, M. D.

(Address) Framingham, Mass. Date 4/15 64

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 16, 64

7 NAME OF FUNERAL DIRECTOR: George A. Mitchell

ADDRESS: Natick, Mass.

Received and filed May 15 64

Clarence F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Widow

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Theodore Gibson
(Husband's name in full)

12 AGE 84 Years 3 Months 25 Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Domestic
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 020 22 0909

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER: John E. E. Goward

18 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass.

19 MAIDEN NAME OF MOTHER: Josephine M. Locke

20 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

21 Informant Mrs. Ralph True
(Address) 53 C St. Framingham, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED April 15, 64

COPY OF CERTIFICATE OF DEATH

CERTIFICATE OF DEATH
STATE OF NEW HAMPSHIRE

TOWN OR CITY CLERK'S NO. 27

1. NAME OF DECEASED (TYPE OR PRINT) A. (FIRST) Herbert	B. (MIDDLE)	C. (LAST) Tufts	2. DATE OF DEATH (MONTH) 4 (DAY) 19 (YEAR) 64
3. PLACE OF DEATH A. COUNTY Carroll		4. USUAL RESIDENCE (WHERE DECEASED LIVED. IF INSTITUTION: RESIDENCE BEFORE ADMISSION.) A. STATE Mass B. COUNTY	
B. CITY OR TOWN Wolfeboro	C. LENGTH OF STAY (IN THIS PLACE) 11 days	C. CITY (GIVE ACTUAL TOWN OF RESIDENCE, NOT MAILING ADDRESS). OR TOWN Southboro	
D. FULL NAME OF HOSPITAL OR INSTITUTION Huggins Hospital		D. STREET (IF RURAL, GIVE LOCATION) ADDRESS	E. IS RESIDENCE ON FARM? YES ☐ NO ☒
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☐ DIVORCED ☐ NEVER MARRIED ☐ WIDOWED ☒	8. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE)
9. DATE OF BIRTH 7/31/90	10. AGE (IN YEARS LAST BIRTHDAY) 73	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.	11A. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Contractor
11B. KIND OF BUSINESS OR INDUSTRY			
12. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) Middleton, N.H.	13. CITIZEN OF WHAT COUNTRY? US	14. FATHER'S NAME Joseph Wright Tufts	
15. MOTHER'S MAIDEN NAME Cora Cook		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES OF SERVICE)	17. SOC. SEC. NO.
18A. INFORMANT Mrs. Gladys Binder		18B. ADDRESS Southboro, Mass.	

MEDICAL CERTIFICATION

19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A)	Carcinoma of Rectum	2 yrs
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST. DUE TO (B)	Bladder & Pelvic Metastases from 19A	1 month
DUE TO (C)	Liver Metastases from 19A	3-6 Month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(A)	Secondary Anemia	20. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

21A. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	21B. DESCRIBE HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II OF ITEM 19.)	
21C. TIME OF INJURY MONTH DAY YEAR HOUR M.		
21D. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21E. PLACE OF INJURY (E. G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)	21F. CITY, TOWN OR LOCATION COUNTY STATE

22. *I attended the deceased from* 4/8/64 *to* 4/19/64 *and last saw* ~~him~~ *alive on* 4/19/64
Death occured at 5:50 A.M. *on the date stated above; and to the best of my knowledge, from the causes stated.*

23A. SIGNATURE Ralph Adams	(DEGREE OR TITLE) MD	23B. ADDRESS Wolfeboro, N.H.
23C. DATE SIGNED 4/20/64		

24A. BURIAL ☒ CREMATION ☐ ENTOMBMENT ☐ REMOVAL ☐	24B. DATE 4/21/64	24 C. NAME OF CEMETERY OR CREMATORY Tufts Cemetery	24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Middleton, N.H.
IF ENTOMBED 24E. PLACE OF BURIAL (NAME OF CEMETERY)	LOCATION (CITY, TOWN, COUNTY) (STATE)		DATE
25. FUNERAL DIRECTOR'S SIGNATURE Robert A. Peaslee, Farmington, N.H.	ADDRESS	COUNTERSIGNED-AGENT (CITY BD. OF HEALTH)	DATE
DATE REC'D BY TOWN OR CITY CLERK 4/20/64	CLERK'S OWN SIGNATURE Alice A. Cole	CLERK OF Wolfeboro, N.H.	

A true copy, Attest: Alice A. Cole *Clerk of* Wolfeboro, N.H. *Dated* 4/20/64 *19*

VS 17 Received April 27, 1964 Eleanor F. Burke

43940-x 7-62—25M

FORM R-303

Filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9

Registered No. 253

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

Southboro (City or Town making this return)

No. East Main St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James (First Name) Joseph (Middle Name) Gralton (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. East Main St St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 65 years ..... months ..... days. In place of residence 65 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 4 (Day) 1964 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes: Heart Disease
Presumably coronary occlusion
(found dead in bed)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19..

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) S. Alden Gralton, M. D.
S. ALDEN GRALTON M.D
(Print or Type Name)

(Address) Grafton Mass Date May 4 1964

7 Rural Cemetery Southboro, Mass.
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL May 6, 1964

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass

Received and filed May 8 1964 19..
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
M	White	Widowed

12 If married, widowed, or divorced
HUSBAND of Mary (Donnelly) Gralton
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

13 DATE OF BIRTH Feb. 4, 1878

14 AGE 86 Years 3 Months 0 Days — If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation Chauffeur
(Kind of work done during most of working life)

16 Industry or Business Retired

17 Social Security No. 024-05-8967

18 BIRTHPLACE (City) (State or country) Leitrim Ireland

PARENTS

19 NAME OF FATHER Lewis Gralton

20 BIRTHPLACE OF FATHER (City) (State or country) Leitrim Ireland

21 MAIDEN NAME OF MOTHER Catherine Sullivan

22 BIRTHPLACE OF MOTHER (City) (State or country) Leitrim Ireland

23 Informant Catherine Gralton
(Address) East main St. Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Susan Meredith Agent
(Signature of Agent of Board of Health or other)

(Official Designation) May 5 1964 (Date of Issue of Permit)

MEDICAL

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

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50M-10-61-931673

The Commonwealth of Massachusetts

Duplicate 17

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH

Middlesex
(County)

Marlborough
(City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alfred N. DiMilla
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR,) ----

(a) Residence. No. Turnpike Road (Usual place of abode) St. xx Fayville (Southboro) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 8, 1964
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 22, 1964, to May 8, 1964.
I last saw him alive on May 7, 1964 death is said to have occurred on the date stated above, at 12:35a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral embolism	2 hrs
Due To (b)	Rheumatic heart disease	20 yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? no
What test confirmed diagnosis? EKG, Clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) John Paul Ahearn, M. D.

(Address) Marlboro, Mass. Date May 8 1964

6 Rural Cemetery, Southboro, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 11 1964

7 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS 57 Main St. Marlboro, Mass.

Received and filed June 10 64

Eleanora T. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Male	White	Married

11 If married, widowed, or divorced
HUSBAND of Marlene Peros
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 AGE 35 Years .....Months .....Days. If under 24 hours .....Hours .....Minutes

13 Usual Occupation: proprietor
(Kind of work done during most working life)

14 Industry or Business: Shoe store

15 Social Security No. 018-20-1922

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Pasquale DiMilla

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Maria Panza

20 BIRTHPLACE OF MOTHER (City) (State or country) Somerville, Mass.

21 Informant (Address) Marlene DiMilla - wife
Turnpike Rd. Fayville, Mass.

A TRUE COPY
ATTEST: Elsie S. Lapine
(Registrar of City or Town where death occurred)

DATE FILED May 12 1964

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough
(City or Town making this return)

Registered No. 106

PLACE OF DEATH

1 Middlesex (County)
Marlborough (City or Town)
No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alfred N. DiMilla
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR,) ----

(a) Residence. No. Turnpike Road (Usual place of abode) xx Fayville (Southboro) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 8, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 22 64 to May 8 64
I last saw him alive on May 7 64 death is said to have occurred on the date stated above, at 12:35a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral embolism — 2 hrs
Due To (b) Rheumatic heart disease — 20 yrs
Due To (c)
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? EKG, Clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John Paul Ahearn, M. D.
(Address) 14 Winthrop St. Marlborough, Mass. Date May 8 64

6 Place of Burial or Cremation Rural Cemetery, Southboro, Mass.
DATE OF BURIAL May 11 (City or Town) 64

7 NAME OF FUNERAL DIRECTOR John P. Rowe
ADDRESS 57 Main St. Marlboro, Mass.

Received and filed May 12 15 64
Edward F Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Marlene Peros (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 35 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Proprietor (Kind of work done during most working life)

14 Industry or Business: Shoe store

15 Social Security No. 018-20-1922

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Pasquale DiMilla

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Maria Panza

20 BIRTHPLACE OF MOTHER (City) (State or country) Somerville Mass

21 Informant (Address) Marlene DiMilla - wife Turnpike Rd. Fayville, Mass.

A TRUE COPY
ATTEST: Peter P. Cottone
(Registrar of City or Town where death occurred)
Agent
DATE FILED May 9, 1964 19

13

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-8-56-918227

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harriet Turenne (Gordon)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. Oak Hill Rd. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death D.O.A. years ..... months ..... days. In place of residence 26 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 9, 1964
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary insufficiency
Rheumatic heart disease

5 Accident, suicide, or homicide (specify) Natural

Date and hour of injury 11:32am 5/9 19 64

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Antonio A. Matarese, M. D.

(Address) Framingham, Mass. Date 5/9 19 64

7 Newton Crematory, Newton, Mass.
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL May 11, 19 64

8 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth

ADDRESS Framingham, Mass.

Received and filed May 15 19 64

Eleanor F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Wilfred J. Turenne
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 62 Years 8 Months 20 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housework
(Kind of work done during most of working life)

15 Industry or Business: At home

16 Social Security No. 020-05-5841

17 BIRTHPLACE (City) (State or country) Groton, Vermont

PARENTS

18 NAME OF FATHER William Gordon

19 BIRTHPLACE OF FATHER (City) ..... (State or country) Scotland

20 MAIDEN NAME OF MOTHER Jane D. Daniels

21 BIRTHPLACE OF MOTHER (City) Groton, (State or country) Vermont

22 Informant Wilfred J. Turenne
(Address) Oak Hill Rd., Southboro, Mass

A TRUE COPY.
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED May 11, 19 64

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. 340 Winter St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Edgar Watkins (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. Main St Southboro (City or town and State) (Usual place of abode)

Length of stay: In place of death ..... years ..... months 7 days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 10, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 27 Im 48 to May 10 64

I last saw h alive on May 9 64, death is said to have occurred on the date stated above, at 10:00A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Pulmonary emboli	36hrs
Due To (b) stasis	1 wk
Due To (c) Arteriosclerosis (Cardiac, cerebral, general)	5 yrs.
OTHER SIGNIFICANT CONDITIONS Urinary retention	2 wks

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 5/10 1964

6 Rural Cemetery, Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 12 1964

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed May 15 1964

Eleanor F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Male	white	married

11 If married, widowed, or divorced HUSBAND of Esther Nourse (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 83 Years 8 Months 21 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Railroading & Telegraphy (Kind of work done during most of working life)

14 Industry or Business: rail roads

15 Social Security No. 705-18-0649

16 BIRTHPLACE (City) (State or country) Newport, Vt.

PARENTS

17 NAME OF FATHER William G. Watkins

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Armina Brewer

20 BIRTHPLACE OF MOTHER (City) (State or country) Ennosburg Falls, Vermont

21 Informant Mrs. Esther Watkins

(Address) Main St. Southboro, Mass.

A TRUE COPY ATTEST: Michael J. Ward (Registrar of City or Town where death occurred)

DATE FILED May 13 1964

100M-9-63-936348

16

FORM R-305

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — MARGIN RESERVED FOR BINDING
THIS IS A PERMANENT RECORD

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25M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Marlborough (City or Town)

No. D.O.A. St. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth (Richards) Binder (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) ----

(a) Residence. No. ..... (Usual place of abode) East Main Street St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence 12 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 11, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Heart disease, coronary sclerosis
Collapsed at home. Dead on arrival
Marlboro Hospital

5 Accident, suicide, or homicide (specify) none

Date and hour of injury .....19.....

If accidental, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? no no

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) R. N. Rittenhouse, M. D.

(Address) 540 Bolton St. Date May 9 19 64

7 Place of Burial, Cremation or Removal (City or Town) Rural Cemetery, Southboro, Mass.

DATE OF BURIAL May 13 19 64

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed May 14 19 64

(Registrar of City or Town where deceased resided)

Rec'd June 1 Clarence F. Burke

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Female	White	YES ☐ NO ☐	Married

12a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of William G. Binder, Sr.
(Husband's name in full)

13 DATE OF BIRTH .....

14 AGE 68 Years 10 Months 1 Days — If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Housewife
(Kind of work done during most of working life)

16 Industry or Business: At Home

17 Social Security No. 161-22-1041

18 BIRTHPLACE (City) (State or country) Forest City, Penna.

PARENTS

19 NAME OF FATHER Thomas Richards

20 BIRTHPLACE OF FATHER (City) (State or country) Swansea Wales

21 MAIDEN NAME OF MOTHER Mary Llewelyn

22 BIRTHPLACE OF MOTHER (City) (State or country) Wilkes Barre Pennsylvania

23 Informant William G. Binder, Jr.
(Address) Lyman St. Southboro, Mass.

A TRUE COPY.
ATTEST: Rita A. Lapsine
(Registrar of City or Town where death occurred)

DATE FILED ..... 19.....

Agent May 14, ...

FORM R-303 B

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

EM-3-65-822167

OUTS OF - TOWN

1 PLACE OF DEATH: Suffolk (County) — Boston (City or Town)

The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 04860

No. Boston City Hospital St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Leonard Fowler (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Parker St. St. Ward Cordeville (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. days. How long in U. S., if of foreign birth? yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: MALE

4 COLOR: WHITE

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: SINGLE

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 19 Years 6 Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: U. S. Navy

10 Industry or Business: Armed Service

11 Social Security No. 023-32-8778

12 BIRTHPLACE (City) (State or country): Saxonville Mass.

PARENTS

13 NAME OF FATHER: Henry B. Fowler

14 BIRTHPLACE OF FATHER (City) (State or country): Framingham Mass.

15 MAIDEN NAME OF MOTHER: Rita L. Birmingham

16 BIRTHPLACE OF MOTHER (City) (State or country): Milford - Mass

17 Informant: Henry B. Fowler Relation, if any: (Father)
(Address) Parker St. Cordaville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (Official Designation)

B 26829

May 15 1964 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: May 14 1964 (Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fractures of Skull
Passenger in Car Striking Light pole Accidental
May 13, 1964

20 IN WHAT CITY OR TOWN WAS INJURY SUSTAINED? Boston

(Signed) Geo. W. Burton M. D.

(Address) 784 Mass. Avenue Date 5-15-64 19

21 PLACE OF BURIAL CREMATION OR REMOVAL: St. Stephens (Cemetery) Framingham (City or town)

DATE OF BURIAL May 18 1964

22 NAME OF UNDERTAKER: Eugene McCarthy

ADDRESS 11 Lincoln St, Framingham

Received and filed MAY 19 1964 19

William J. Davis (Registrar)

Rec'd 7/22/64

FORM R-304

10M-6-62-933404

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH
(STILLBIRTH)

To be filed for burial permit with Board of Health or its Agent. 14

Registered No. 253

1 PLACE OF DELIVERY: Worcester (County); Southborough (City or Town); No. Marlboro Rd, Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 NAME OF FETUS (if given) Baby Taylor

3 DATE OF DELIVERY May 18 1964 (Month) (Day) (Year)

4 SEX Male ..... Female X Undetermined .....

5 COLOR (if determined) W

6 THIS BIRTH (Check one) Single X Twin ..... Triplet .....

7 IF MULTIPLE BIRTH, BORN: 1st ..... 2nd ..... 3rd .....

FATHER

8 FULL NAME Russell Paul Taylor

9 RESIDENCE, NO. Marlboro, Road STREET
CITY OR TOWN Southboro STATE Mass.

10 COLOR OR RACE W

11 AGE AT TIME OF THIS DELIVERY 36 (Years)

12 PLACE OF BIRTH Marlboro, Mass. (City or Town) (State or country)

13 OCCUPATION Laborer

MOTHER

14 MAIDEN NAME Phyllis M. Farina
PRESENT NAME " " Taylor

15 RESIDENCE, NO. Marlboro Road STREET
CITY OR TOWN Southboro STATE Mass

16 COLOR OR RACE W

17 AGE AT TIME OF THIS DELIVERY 31 (Years)

18 PLACE OF BIRTH Hudson Mass. (City or Town) (State or country)

19 INFORMANT Russell P Taylor -

20 PREVIOUS DELIVERIES TO MOTHER (Do not include this fetus) 2
(a) How many children are now living? 2
(b) How many children were born alive but are now dead? 0
(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY completed weeks 22

22 Weight Lb. 1 Oz. 2 OF FETUS (or Grams)

23 WHEN DID FETUS DIE? Before Labor / During Labor or Delivery / Unknown

24 AUTOPSY Yes / No

In giving CAUSE OF FETAL DEATH do not enter more than one cause for each of (a), (b) and (c)

Fetal or maternal condition causing fetal death (do not use such terms as stillbirth or prematurity.)

Fetal and/or maternal conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Premature labor + delivery
Due To (b) Premature ruptd. membs
Due To (c) ?

OTHER SIGNIFICANT CONDITIONS None

Conditions of fetus or mother which may have contributed to fetal death, but, in so far as is known, were not related to cause given in (a).

I HEREBY CERTIFY that this delivery occurred on the date stated above at 10.45 PM m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
John J. Lepore M.D. M.D.
JOHN J. LEPORE, M.D.
(PRINT OR TYPE NAME)

Address 96 W. Main St Marlboro Mass Date 5/19 1964

26 Rural Cemetery Southboro Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 20. 1964

27 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed May 25, 1964 19 .....
Eleanora F. Burke (Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Susan Ciocatelli Agent
(Signature of Agent of Board of Health or other)

(Official Designation) May 21, 1964 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-6-62-933104

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

15

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary M. Mooney (Doherty) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Highland St., St. Southboro, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months.....9.....days. In place of residence.....60.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 2 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 30 19 53 to June 2, 19 64

I last saw her alive on June 1, 19 64, death is said to have occurred on the date stated above, at 7:55 am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial infarction	8 dys
Due To (b) Arteriosclerosis	-
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Diabetes mellitus	6 yrs

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Timothy Stone, M. D.

(Address) Southboro Date 6/2/64

6 Holy Cross Cem., Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 5 19 64

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed June 24 19 64

Edward F Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of George A. Mooney, Sr.
(Husband's name in full)

12 AGE 78 Years 8 Months 6 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 028-14-7296

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER John J. Doherty

18 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass.

19 MAIDEN NAME OF MOTHER Mary M. Powers

20 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

21 Informant George A. Mooney, Jr.

(Address) Highland St., Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED June 4 19 64

FORM R-301A

N.B.–THIS IS A PERMANENT RECORD. Use only STATE APPROVED black ink or black typewriter ribbon.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates.

SEE CHAP. 46, §§ 9 & 10., CHAP. 114 §§ 45, 46; CHAP. 38 § 6.)

100M-10-58-923886

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

18

To be filed for burial permit with Board of Health or its Agent.

Registered No. 253

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. Marlboro Road, St. Southboro, Mass. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret (Crockett) Smith
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Marlboro Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 15 years ... months ... days. In place of residence 15 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 27 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3-28, 1964, to 6-27-64, 19...
I last saw her alive on June 17, 1964, death is said to have occurred on the date stated above, at 10:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Hepatic coma	36 hrs
Due To (b) Metastasis from the pancreas	4 mo.
Due To (c) Carcinoma of the pancreas	5 mo.
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? No
What test confirmed diagnosis? Laparotomy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) William J. George, M. D.
(Address) 118 Union Avenue Framingham, Mass. Date 6-29 64

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 30, 1964

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St Southboro, Mass.

Received and filed July 1 1964
Eleonora F. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
F	White	Married

10a If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of Scott K Smith
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 42 Years 5 Months 12 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 019-18-6581

16 BIRTHPLACE (City) Milford
(State or country) Mass

PARENTS

17 NAME OF FATHER William Crockett

18 BIRTHPLACE OF FATHER (City) Gloucester
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Florence Eames

20 BIRTHPLACE OF MOTHER (City) Cambridge
(State or country) Mass.

21 Informant (Address) Scott K. Smith Marlboro, Road Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sina A Tocaletta Agent
(Signature of Agent of Board of Health or other)

(Official Designation) June 29-1964 (Date of Issue of Permit)

FORM R-303

be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20

Southboro
(City or Town making this return)

Registered No. 253

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)

No. Turnpike Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dante (First Name) M (Middle Name) Trioli (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence. No. Turnpike Road (rte #9) St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 40 years ... months ... days. In place of residence 40 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 15, (Day) 1964 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Rupture of Esophageal Varices
(Found Dead in Kitchen

5 Accident, suicide, or homicide (specify) None

Date and hour of injury ... 19...

IF ACCIDENTAL, was injury causally related to the death? ...

Where did Injury occur? ... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ... (Specify type of place)

Manner of Injury ... (How did injury occur?)

Nature of Injury ...

While at work? ... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) [signature], M. D.

[signature]
(Print or Type Name)

(Address) 540 [illegible] St, [illegible] Date 8-15 1964

7 Rural Southboro, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Aug. 18, 1964

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main Street, Southboro, Mass.

Received and filed August 20 1964

[signature] Burke

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
M	White	Single

12 If married, widowed, or divorced HUSBAND of ... (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

13 AGE 64 Years 4 Months 16 Days — If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Metropolitan District Comm.
(Kind of work done during most of working life)

15 Industry or Business: Water Works

16 Social Security No. 030-09-4622

17 BIRTHPLACE (City) Clinton
(State or country) Mass.

PARENTS

18 NAME OF FATHER John J. Trioli

19 BIRTHPLACE OF FATHER (City) Piacenza
(State or country) Italy

20 MAIDEN NAME OF MOTHER Clementina Cordani

21 BIRTHPLACE OF MOTHER (City) Piacenza
(State or country) Italy

22 Informant (Address) Mrs. Thomas O'Brien
Turnpike Road, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. [illegible], Agent
(Signature of Agent of Board of Health or other)

(Official Designation) 8/18/64 (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE October 2, 1942

DATE OF DISCHARGE March 15, 1943

RANK, RATING Private

ORGANIZATION AND OUTFIT HDq Co. 59th Signal Bn, Fort Jackson, S.C.

SERVICE NUMBER 31184241

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954 requires Physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1959, requires Physicians to print or type name under signature.

100M 3-61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 21

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Parkerville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Richard Dudley Fay (First Name) (Middle Name) (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parkerville Rd. St. Southboro (If nonresident, give city or town and State) (Usual place of abode)

Length of stay: In place of death 1 years months days. In place of residence 1 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: SEPT (Month) 9 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JUNE 24, 1963, to SEPT 9, 1964

I last saw him alive on SEPT 8, 1964, death is said to have occurred on the date stated above, at 10:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic Renal Disease	1 yr.
Due To (b) Arteriosclerosis, general	—
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease	10 yrs.
Rheumatic Heart Disease	60 yrs

Was autopsy performed? no

What test confirmed diagnosis? prior hospital study

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) Timothy P. Stone, M. D.

TIMOTHY P. STONE (Print or Type Name)

(Address) MAIN ST., SOUTHBORO Date Sept 10 1964

6 Rural Cemetery Southboro (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL September 11, 1964

7 NAME OF FUNERAL DIRECTOR Geo. Sessions for Geo. Sessions Sons Co.

ADDRESS 71 Pleasant St.-Worcester

Received and filed September 11 1964

Edmund F. Burke (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
male	white	YES ☒ NO ☐	

11a If married, widowed, or divorced HUSBAND of Hestor Lawrence (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH January 13, 1891

13 AGE 73 Years 7 Months 26 Days; If under 24 hours Hours Minutes

14 Usual Occupation: retired Professor Emeritus (Kind of work done during most of working life)

15 Industry or Business: Mass. Institute of Technology

16 Social Security No.

17 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

18 NAME OF FATHER Dudley Bowditch Fay

19 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass.

20 MAIDEN NAME OF MOTHER Katherine Gray

21 BIRTHPLACE OF MOTHER (City) (State or country) Dorchester, Mass.

22 Informant (Address) Mrs. Richard D. Fay Parkersville Rd.-Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Chairman, Board of Health (Official Designation) Sept 10, 1964 (Date of Issue of Permit)

FORM R-303

be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 22

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town)

No. Dougherty Tool Co Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sidney P. Gibson (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence No. 109 A ~~127~~ Mechanic St Marlboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 16 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural Causes: Heart Disease
Presumably Coronary Occlusion
(Sudden Death)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19..

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) S. Elden Gould, M. D.
S. ELDEN GOULD (Print or Type Name)

(Address) Grafton Date 9-16 1964

7 Immaculate Conception Marlboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 19 1964

8 NAME OF FUNERAL DIRECTOR John W. Sullivan

ADDRESS 378 Lincoln Marlboro

Received and filed September 18 1964

Eleanor F. Burke (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Married

12 If married, widowed or divorced
HUSBAND of Rita Magoon (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

13 AGE 60 Years 7 Months ..... Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Tool Maker (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. 017-05-6976

17 BIRTHPLACE (City) (State or country) England

PARENTS

18 NAME OF FATHER Philip Gibson

19 BIRTHPLACE OF FATHER (City) (State or country) England

20 MAIDEN NAME OF MOTHER Elizabeth Monaghan

21 BIRTHPLACE OF MOTHER (City) (State or country) England

22 Informant Sidney Gibson jr Son
(Address) 41 E. Lincoln Marl.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

9-17-64
(Date of Issue of Permit)

MEDICAL

FORM R-301A

N.B.—THIS IS A PERMANENT RECORD. Use only STATE APPROVED black ink or black typewriter ribbon.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean mode of dying, such as heart failure, asphenia, etc. It means disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates.

SEE CHAP. 46, §§ 9 & 10., CHAP. 114 §§ 45, 46; CHAP. 38 § 6.)

100M-10-58-923886

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

23

To be filed for burial permit with Board of Health or its Agent.

Registered No. 253

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Wallace Lynn Dyer
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence, No. School St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 20 years ... months ... days. In place of residence 20 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept (Month) 23 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY 23, 1949, to SEPT 23, 1964
I last saw him alive on SEPT 21, 1964, death is said to have occurred on the date stated above, at 6:00 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia	2 days
Due To (b) Chronic Bronchitis / Emphysema	15 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease	2 yrs

Was autopsy performed? no
What test confirmed diagnosis? clinical diagnosis

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify —

(Signed) Timothy P. Stone, M. D.
(Address) TIMOTHY P. STONE MAIN ST, SOUTHBORO Date Sept 24 1964

6 Elmwood Cemetery East Sumner Maine
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 26 1964

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed September 30 1964
Theresa F Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED (write the word)
M	White	Widowed

10a If married, widowed, or divorced
HUSBAND of Gracie Abbott
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 5 Months 22 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Farmer
(Kind of work done during most of working life)

14 Industry or Business: Farm

15 Social Security No. 00-503-7137

16 BIRTHPLACE (City) Hartford
(State or country) Maine

PARENTS

17 NAME OF FATHER George F. Dyer

18 BIRTHPLACE OF FATHER (City) Hartford
(State or country) Maine

19 MAIDEN NAME OF MOTHER Georgiana Keene

20 BIRTHPLACE OF MOTHER (City) Hartford
(State or country) Maine

21 Informant Mrs. Rachel Hosmer
(Address) School St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Mary Sunai A Tocatelli, Agent
(Signature of Agent of Board of Health or other)

(Official Designation)

9-25-64
(Date of Issue of Permit)

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough
(City or town making return)
Registered No. 257

PLACE OF DEATH

1 Middlesex (County)
Marlborough (City or Town)
No. D.O.A. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert A. Kelly (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) W.W. II ?

(a) Residence. No. (Usual place of abode) Fay School St. Southborough, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence ....years....months 10 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 26, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Heart disease, presumably coronary sclerosis (collapsed on dance floor, D.O.A. Marlboro Hospital

5 Accident, suicide, or homicide (specify) none

Date and hour of injury ....19....

If accidental, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) R. N. Rittenhouse, M. D.

(Address) 540 Bolton St. Marlboro, Mass. Date Sept. 26 64

7 Place Rural Cemetery, Southboro, Mass.

DATE OF BURIAL October 29 64

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed October 30, 1964

(Registrar of City or Town where deceased resided)

Nov. 6, 1964 Adams & Burke

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Male	White	YES ☐ NO ☐	Married ☐

12a If married, widowed, or divorced
HUSBAND of Marie B. Fox (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH

14 AGE 42 Years 0 Months 14 Days — If under 24 hours: Hours Minutes

15 Usual Occupation: Soldier & unknown (Kind of work done during most of working life)

16 Industry or Business: U.S. Army & Navy Service

17 Social Security No. 151-30-4862

18 BIRTHPLACE (City) (State or country) Chicago, Illinois

PARENTS

19 NAME OF FATHER Cannot be learned Kelly

20 BIRTHPLACE OF FATHER (City) (State or country) Chicago Illinois

21 MAIDEN NAME OF MOTHER Theresa A. Jennings

22 BIRTHPLACE OF MOTHER (City) (State or country) Cannot be learned Ireland

23 Informant (Address) U.S. Army Records Tago St. Louis, Missouri

A TRUE COPY.
ATTEST: (Registrar of City or Town where death occurred)
Peter P. Cottone

DATE FILED Oct. 28, 1964

Agent

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE Cannot be learned

DATE OF DISCHARGE Feb. 29, 1956

RANK, RATING Sgt. First Class Ret.

ORGANIZATION AND OUTFIT Cannot be learned

SERVICE NUMBER ER 12 032 278

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Asadour Topalian (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Residence. No. Woodland Rd., St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death DOA years ..... months ..... days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 5 (Day) 1964 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary disease

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Antonio A. Matarese, M. D.

(Address) Framingham Date 10/5/ 64 19.....

7 Forest Hills Crem. Boston
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL October 8 64

8 NAME OF FUNERAL DIRECTOR Eastman Funeral Service

ADDRESS Boston, Mass.

Received and filed October 26 19 64

Clarence F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male

10 COLOR white

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word) married

12 If married, widowed, or divorced
HUSBAND of Berjouhie Dingilian
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

13 AGE 71 Years 2 Months 29 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Electrical engineer
(Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. 031-09-0596

17 BIRTHPLACE (City) (State or country) Marash, Armenia

PARENTS

18 NAME OF FATHER Panos Topalian

19 BIRTHPLACE OF FATHER (City) (State or country) Armenia

20 MAIDEN NAME OF MOTHER Esther Amiralion

21 BIRTHPLACE OF MOTHER (City) (State or country) Armenia

22 Informant (Address) Mrs. Berjouhie C. Topelian
Woodland Rd.,
Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED October 13, 1964 19.....

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... 6/24/18 .....

DATE OF DISCHARGE ..... 11/30/18 .....

RANK, RATING ..... Sgt. .....

ORGANIZATION AND OUTFIT ..... 151st Depot Brigade (Army) .....

SERVICE NUMBER ..... 2726896 .....

.....

FORM R-301A

N.B.—THIS IS A PERMANENT RECORD. Use only STATE APPROVED black ink or black typewriter ribbon.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean mode of dying, such as heart failure, asphenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates.

SEE CHAP. 46, §§ 9 & 10., CHAP. 114 §§ 45, 46; CHAP. 38 § 6.)

100M-10-58-923886

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 253

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Main Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lewis F. Horton Sr.
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Main Street St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 18 years ... months ... days. In place of residence 18 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. (Month) 7 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY 16, 1949, to OCT. 7, 1964
I last saw him alive on OCTOBER 5, 1964, death is said to have occurred on the date stated above, at 4:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CARCINOMA, LUNG undifferentiated.	7 mos.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS —	

Was autopsy performed? No
What test confirmed diagnosis? X-Ray, Scalene Node Biopsy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify —

(Signed) Timothy P. Stone, M. D.
(Address) TIMOTHY P. STONE SOUTHBORO, MASS Date Oct. 8 1964

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 10, 1964 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro Mass.

Received and filed October 13 19 64
Elvina F. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED (write the word)
M	White	Married

10a If married, widowed, or divorced HUSBAND of Mary E. Madden
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 53 Years 5 Months 1 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: GunSmith and Merchant
(Kind of work done during most of working life)

14 Industry or Business: Sporting Goods Store

15 Social Security No. 021-10-4052

16 BIRTHPLACE (City) Swansea
(State or country) Mass.

PARENTS

17 NAME OF FATHER Charles L. Horton

18 BIRTHPLACE OF FATHER (City) Dighton
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Clara Morris

20 BIRTHPLACE OF MOTHER (City) Dighton
(State or country) Mass.

21 Informant Mrs. Mary Madden Horton
(Address) Main St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit ~~permit~~ was issued:

Mrs Sina A Iocabelli
(Signature of Agent of Board of Health or other)

(Official Designation) 10-9-64 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-6-62-933u04

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. 27

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. 340 Winter St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Vesta Louise Davis (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main St. (Usual place of abode) Southboro (City or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: November 10, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1962, to Nov. 10, 1964. I last saw her alive on Nov. 9, 1964 death is said to have occurred on the date stated above, at 12:50A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Bronchopneumonia	1 day
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Cerebral thrombosis	2 wks.

Was autopsy performed? no

What test confirmed diagnosis? Clinical appraisal

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 11/10 1964

6 Rural Cemetery, Southboro, Mass. (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL November 12 1964

7 NAME OF FUNERAL DIRECTOR: Richard P. Coldwell

ADDRESS: Marlboro, Mass.

Received and filed ..... 19....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Female	white	Single

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 87 Years 3 Months 18 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: seamstress (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 033-26-6144

16 BIRTHPLACE (City) (State or country): Lewiston, Maine

PARENTS

17 NAME OF FATHER: John A. Davis

18 BIRTHPLACE OF FATHER (City) (State or country): Newportland, Maine

19 MAIDEN NAME OF MOTHER: Mary L. McFarland

20 BIRTHPLACE OF MOTHER (City) (State or country): Skowhegan, Maine

21 Informant: Miss Delia N. Davis

(Address) Main St. Southboro, Mass.

A TRUE COPY

ATTEST: [signature] (Registrar of City or Town where death occurred)

DATE FILED November 12 1964

ORM R-303

filed for burial permit
th Board of Health
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.
N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

Deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-93648

1 PLACE OF DEATH

OUT - OF - TOWN

Suffolk (County)

Boston (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BOSTON + SOUTHBORO 33
(City or Town making this return)

Registered No. 10856

Enroute to Massachusetts General Hospital
No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

2 FULL NAME RAYMOND DUMONT
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. Latisquama Road St. Southboro, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 10, 1964
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary occlusion.
Hypertensive cardio-vascular disease.

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? ..... No

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael A. Eubango, M.D., M. D.
(Print or Type Name)

(Address) Boston Date 11/11 19 64

7 RURAL CREMATORY WORCESTER
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL NOV 14 1964

8 NAME OF FUNERAL DIRECTOR DONALD C MORRIS

ADDRESS MAIN ST SOUTHBORO

Received and filed NOV 13 1964 Dec. 18, 19 1964

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
M	WHITE	MARRIED

12 If married, widowed, or divorced
HUSBAND of BARBARA CRAIG
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

13 AGE 51 Years 0 Months 17 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: SALES REPRESENTATIVE
(Kind of work done during most of working life)

15 Industry or Business: SHOES

16 Social Security No. 020-14-6592

17 BIRTHPLACE (City) (State or country) HAVERHILL MASS

PARENTS

18 NAME OF FATHER EDWARD J DUMONT

19 BIRTHPLACE OF FATHER (City) (State or country) ST. ENIDINE CANADA

20 MAIDEN NAME OF MOTHER FLORENCE CHASE

21 BIRTHPLACE OF MOTHER (City) (State or country) HAVERHILL MASS

22 Informant MRS RAYMOND DUMONT
(Address) LATISQUAMA RD. SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Theresa C. Donald C 04270
(Signature of Agent of Board of Health or other)

(Official Designation) Quinn & Burke NOV 11 1964
(Date of Issue of Permit)

CANCELLED

2623

FORM R.301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Worcester (City or Town making this return)

Registered No. 2716

1 PLACE OF DEATH: Worcester (County); Worcester (City or Town); No. St. Vincent Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Primo Borelli (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. Boston Road St. Southboro, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 11 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1964, to Nov. 11, 1964

I last saw him alive on November 11, 1964 death is said to have occurred on the date stated above, at 5:45A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial Insufficiency — 1day

Due To (b) Secondary to Open Heart Surgery — 1Day

Due To (c) Aortic Stenosis + Insufficiency — yrs.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Operation; EKG; Catheterization

5 Was disease or injury in any way related to occupation of deceased? N/A If so, specify

(Signature) Robert C. Maclean, M. D.
Robert C. Maclean
(Print or Type Name)

(Address) St. Vincent Hosp Date 11-11 1964

6 Rural Cemetery Southboro, Mass. (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Nov. 14, 1964

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main Street Southboro, Mass.

Received and filed NOV 13 1964 19

Robert J. O'Keefe (Registrar)

December 18, 1964

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Josephine Fedolfi (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 58 Years 1 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Maintenance Man (Kind of work done during most of working life)

14 Industry or Business Bay State Abrasive Westboro

15 Social Security No. 034-166-114

16 BIRTHPLACE (City) (State or country) Pesaro Italy

PARENTS

17 NAME OF FATHER James Borelli

18 BIRTHPLACE OF FATHER (City) (State or country) Pesaro Italy

19 MAIDEN NAME OF MOTHER Rose Fazio

20 BIRTHPLACE OF MOTHER (City) (State or country) Pesaro Italy

21 Informant Mrs. Josephine Borelli

(Address) Boston Rd. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Nov 11 1964 COMMISSIONER OF PUBLIC HEALTH

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST: Charles M. Colleton (Clerk)

OCM-9-63-936348

FORM R-303

e filed for burial permit
vith Board of Health
or its Agent.

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SOUTHBORO (City or Town making this return)

Registered No. 368 28

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LILLIAN (First Name) MABEL (Middle Name) (Clough) BOOTH (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. ..... (Usual place of abode) Newton Street St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 5 years ..... months ..... days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 16 (Day) 1964 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphixiation, self-induced by placing plastic bag over head.

5 Accident, suicide, or homicide (specify) Suicide

Date and hour of injury 11 AM 11-16 19 64

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) S. Alden Gould M. D.

S. Alden Gould M.D. (Print or Type Name)

(Address) Grafton Date 11-16 19 64

7 Rural Cemetery Southboro, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Nov. 18, 19 64

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed November 20 19 64

Theresa F. Bixbee (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
F	White	Married

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Allison R. Booth
(Husband's name in full)

13 DATE OF BIRTH October 23 1903

14 AGE 61 Years 0 Months 23 Days | If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Crepe Paper Worker
(Kind of work done during most of working life)

16 Industry or Business: Dennison MFG. Co.

17 Social Security No. 019-10-1490

18 BIRTHPLACE (City) Natick
(State or country) Mass.

PARENTS

19 NAME OF FATHER Otis Clough

20 BIRTHPLACE OF FATHER (City) Charlton
(State or country) Mass.

21 MAIDEN NAME OF MOTHER Grace Taylor

22 BIRTHPLACE OF MOTHER (City) Saxonville
(State or country) Mass.

23 Informant Allison R. Booth
(Address) Newton St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Susan Tarbell, Agent
(Signature of Agent of Board of Health or other)

(Official Designation) 11-18-64 (Date of Issue of Permit)

MEDICAL

...ICATE OF DEATH

CERTIFICATE OF DEATH

STATE OF NEW HAMPSHIRE

TOWN OR CITY CLERK'S NO.....

1. NAME OF DECEASED (TYPE OR PRINT)	A. (FIRST) Lucile	B. (MIDDLE) Gregg	C. (LAST) Wilson	2. DATE OF DEATH (MONTH) (DAY) (YEAR) November 18, 1964

3. PLACE OF DEATH

A. COUNTY: Hillsborough

B. CITY OR TOWN: Nashua

C. LENGTH OF STAY (IN THIS PLACE): 4 days

D. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Memorial Hospital

4. USUAL RESIDENCE (WHERE DECEASED LIVED. IF INSTITUTION: RESIDENCE BEFORE ADMISSION.)

A. STATE: N. H.

B. COUNTY: Hillsborough

C. CITY OR TOWN (GIVE ACTUAL TOWN OF RESIDENCE, NOT MAILING ADDRESS): Wilton

D. STREET ADDRESS (IF RURAL, GIVE LOCATION): Wilton Center

E. IS RESIDENCE ON FARM? YES ☐ NO ☒

5. SEX	6. COLOR OR RACE	7.	8. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE)
Female	White	MARRIED ☒ DIVORCED ☐ NEVER MARRIED ☐ WIDOWED ☐	John Henry Wilson

9. DATE OF BIRTH	10. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.	11A. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED)	11B. KIND OF BUSINESS OR INDUSTRY
9-15-1891	73					Housewife	Home

12. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY)	13. CITIZEN OF WHAT COUNTRY?	14. FATHER'S NAME
Nashua, N. H.	USA	David A. Gregg

15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES OF SERVICE)	17. SOC. SEC. NO.
Ella Fox	no	---

18A. INFORMANT	18B. ADDRESS
Mrs. Charles B. Sullivan	Wilton, N. H.

MEDICAL CERTIFICATION

19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (A): Massive intraventricular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST.

DUE TO (B): Generalized arteriosclerosis — years

DUE TO (C): Long-standing bronchial asthma with emphysema — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(A)

20. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

21A. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	21B. DESCRIBE HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II OF ITEM 19.)
21C. TIME OF INJURY MONTH DAY YEAR HOUR M.	

21D. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21E. PLACE OF INJURY (E. G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)	21F. CITY, TOWN OR LOCATION COUNTY STATE

22. *I attended the deceased from* 11-14-64, *to* 11-18-64 *and last saw* her/him *alive on* 11-18-64

Death occured at 8:00 A.M. *on the date stated above; and to the best of my knowledge, from the causes stated.*

23A. SIGNATURE	(DEGREE OR TITLE)	23B. ADDRESS	23C. DATE SIGNED
Wallace F. Buttrick	M. D.	Nashua, N. H.	11-18-64

24A. BURIAL ☒ CREMATION ☐ ENTOMBMENT ☐ REMOVAL ☐	24B. DATE	24 C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE)
	11-20-64	Rural Cemetery	Southboro, Mass.

IF ENTOMBED 24E. PLACE OF BURIAL (NAME OF CEMETERY)	LOCATION (CITY, TOWN, COUNTY) (STATE)	DATE

25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	COUNTERSIGNED-AGENT (CITY BD. OF HEALTH)	DATE
Nelson Funeral HOmes	Wilton, N. H.	Joan Gauthier	11-18-64

DATE REC'D BY TOWN OR CITY CLERK	CLERK'S OWN SIGNATURE	CLERK OF
November 18, 1964	Edward S. LeBlanc	Nashua, N. H.

A true copy, Attest: Edward S. LeBlanc *Clerk of* Nashua, N. H. *Dated* 11-20-64 *19....*

VS 17 Rec'd November 23, 1964 Eleanora F. Burke Town Clerk

43940-x 7-62—25M

VUORNOS

FORM R-301A

N.B.—THIS IS A RMANENT RECORD. Use only TATE APPROVED black ink or black ypewriter ribbon.

INSTRUCTIONS FOR EDICAL CERTIFICATE

In giving USE OF DEATH do not enter more than one cause for each f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ions which caused th.

onditions, if any, hich gave rise to bove cause (a), tating the under- ying cause last.

Conditions contrib- ng to death but not ated to the terminal ase condition given (a).

lote:- Chapter 137, ts of 1954, requires ysicians to print or e the cause or ses of death on th certificates.

E CHAP. 46, §§ 9 & ., CHAP. 114 §§ 45, 6; CHAP. 38 § 6.)

3886

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 368 29

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)

No. Cordaville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth (Ahola) Vuornos
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran if so specify WAR) None

(a) Residence. No. Cordaville Road St. Southboro, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 30 years ... months ... days. In place of residence 30 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 22 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 14, 1950, to Nov. 22, 1964

I last saw her alive on Nov 21, 1964, death is said to have occurred on the date stated above, at 10:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	CORONARY THROMBOSIS	1 day
Due To (b)	Arteriosclerosis	yrs.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	no	

Was autopsy performed? No
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify —

(Signed) Timothy P. Stone, M. D.
(Address) TIMOTHY P. STONE SOUTHBORO, MASS Date Nov. 23 1964

6 Bay View Cemetery Sandwich Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov 24 19 64

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed November 25 1964
Clarence F. Burke (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
F	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ... (Give maiden name of wife in full)
(or) WIFE of Rev. Bruno Vuornos (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 10 Months 10 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Oulu (State or country) Finland

PARENTS

17 NAME OF FATHER John Ahola

18 BIRTHPLACE OF FATHER (City) Oulu (State or country) Finland

19 MAIDEN NAME OF MOTHER CNBL

20 BIRTHPLACE OF MOTHER (City) Oulu (State or country) Finland

21 Informant Bruno K. Vuornos
(Address) Cordaville Rd. Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Irma C. Orcaletti Agent
(Signature of Agent of Board of Health or other)

(Official Designation) 11-24-64 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

35-(64)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. .....

Lexington
(City or Town making this return)

1 PLACE OF DEATH: Middlesex (County); Lexington (City or Town)

No. Fairlawn Nursing Home, 265 Lowell St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward Hugh Cameron
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. Parerville Road St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 3 years ..... months ..... days. In place of residence 8 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 28 1964
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from September 1961, 28 November 64
I last saw alive on 26 November 64, death is said to have occurred on the date stated above, at 11:15p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Pneumonia — 5 days

Due To
(b) .....

Due To
(c) .....

OTHER SIGNIFICANT CONDITIONS Right Hemiparesis From old cva — 3 yrs.

Was autopsy performed? No
What test confirmed diagnosis? Physical Exam.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Robert C. Stewart, M.D.
(Address) 16 Clarke St. Lexington. Date Nov. 28 64

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 1, 64

7 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons

ADDRESS Boston, Mass.

Received and filed January 19 1965

Edmund F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Widowed

11 If married, widowed, or divorced
HUSBAND of Harriet Wedgwood
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 75 Years 7 Months 14 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Civil Engineer (Retired)
(Kind of work done during most of working life)

14 Industry or Business: Jackson and Moreland

15 Social Security No. 012-18-9213

16 BIRTHPLACE (City) Salem (State or country) Mass.

PARENTS

17 NAME OF FATHER John D. Cameron

18 BIRTHPLACE OF FATHER (City) Pictou County (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Sarah Crosby

20 BIRTHPLACE OF MOTHER (City) Salem (State or country) Mass.

21 Informant Mrs. Mary Blaisdell
(Address) 9 Saw Mill Brook Road Winchester, Mass.

A TRUE COPY
ATTEST: James J. Carroll
(Registrar of City or Town where death occurred)
DATE FILED December 1, 1964

100M-9-63-93634B

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean mode of dying, as heart failure, henia, etc. It means disease, or compli- ions which caused th.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

Note:- Chapter 137, ts of 1954, requires ysicians to print or pe the cause or uses of death on ath certificates, and apter 48, Acts of 59, requires Physi- ans to print or type me under signature.

100M-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

30

To be filed for burial permit with Board of Health or its Agent.

Registered No. 368

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Middle Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Katherine E Neary (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Middle Road (Usual place of abode) St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 74 years 3 months 4 days. In place of residence 74 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 5 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10 August, 1947, to 5 December, 1964

I last saw her alive on 9 November, 1964, death is said to have occurred on the date stated above, at 7 35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS: 0

Was autopsy performed? No

What test confirmed diagnosis? history, findings, course.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Timothy P. Stone, M. D.
Dr. T.P.Stone
(PRINT OR TYPE SIGNATURE)

(Address) Southboro, Mass Date Dec. 7 1964

6 Immaculate Conception Marlboro Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 9, 1964

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main Street, Southboro, Mass

Received and filed December 9 1964
Theresa F. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years 3 Months 4 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Teacher Retired (Kind of work done during most of working life)

14 Industry or Business: Education

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Southboro Mass.

PARENTS

17 NAME OF FATHER John Neary

18 BIRTHPLACE OF FATHER (City) Rosscommon (State or country) Ireland

19 MAIDEN NAME OF MOTHER Delia Moran

20 BIRTHPLACE OF MOTHER (City) Rosscommon (State or country) Ireland

21 Informant Mis Mary Neary
(Address) Middle Road Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Lina A Lovelette (Asst)
(Signature of Agent of Board of Health or other)

(Official Designation)

12-8-64
(Date of Issue of Permit)

FORM R-303

e filed for burial permit
vith Board of Health
or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

31

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Southboro (City or Town making this return)
Registered No. 368

No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Julie (First Name) Ann (Middle Name) Hilditch (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Southville Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 3½ months ..... days. In place of residence ..... years 3½ months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec (Month) 23 (Day) 1964 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Accidental death due to asphyxia from aspiration of vomitus (found dead in crib)

5 Accident, suicide, or homicide (specify)
Date and hour of injury ..... 19....
IF ACCIDENTAL, was injury causally related to the death?
Where did Injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury (How did injury occur?)
Nature of Injury
While at work? Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) S. Alden Gould, M. D.
S. ALDEN GOULD M.D.
(Print or Type Name)
(Address) Grafton Date 12-23 19 64

7 Rural Cemetery Southboro Mass
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL Dec. 24, 1964 19....

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed December 29, 19 64
Eleanora F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
F	White	Single

12 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH Sept. 3, 1964

14 AGE Years 3½ Months Days — If under 24 hours Hours Minutes

15 Usual Occupation Infant
(Kind of work done during most of working life)

16 Industry or Business None

17 Social Security No. None

18 BIRTHPLACE (City) (State or country) Framingham Mass

PARENTS
19 NAME OF FATHER John A. Hilditch
20 BIRTHPLACE OF FATHER (City) (State or country) Framingham Mass
21 MAIDEN NAME OF MOTHER Ann M. Kennedy
22 BIRTHPLACE OF MOTHER (City) (State or country) Framingham Mass

23 Informant John A Hilditch
(Address) Southville Rd. Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Nuo Simonetti Agent
(Signature of Agent of Board of Health or other)
(Official Designation) 12-23-64 (Date of Issue of Permit)

MEDICAL

FORM R-303

be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

37

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town) ..... (City or Town making this return)

Registered No. .....

No. Died in Car Southboro Rt 85 St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Harold (First Name) Ward (Middle Name) (Last Name) {(Was deceased a U. S. War Veteran, if so specify WAR) /

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Main St Southboro Mass St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec 26 - 64
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural Causes: Coronary artery disease, Presumably my acardial infarction (Sudden death at wheel of car)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) S. Alden Ward, M. D.
S. Alden Ward M.D
(Print or Type Name)

(Address) Grafton Date 12-27 1964

7 Maplewood Cemetery Marlboro
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Dec 30 1964

8 NAME OF FUNERAL DIRECTOR John W. Sullivan

ADDRESS 37 Lincoln St Marlboro Mass

Received and filed December 30, 1964

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	WIDOWER

12 If married, widowed, or divorced HUSBAND of Lydia Clark
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

13 AGE 69 Years .....Months 20 Days | If under 24 hours .....Hours .....Minutes

14 Usual Occupation: Farmer Met Dis Comm
(Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. 017-05-4553

17 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

18 NAME OF FATHER Ernest Ward

19 BIRTHPLACE OF FATHER (City) Marlboro (State or country) Mass

20 MAIDEN NAME OF MOTHER Mary Beach

21 BIRTHPLACE OF MOTHER (City) Marlboro (State or country) Mass

22 Informant (Address) Mrs Marjory McGee Daugh 10 Hilltop St North Grafton Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sue A. Escalette Asst
(Signature of Agent of Board of Health or other)

(Official Designation) 12-30-64 (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION ..... in

DATE OF ENTERING MILITARY SERVICE ..... Aug 5 1917

DATE OF DISCHARGE ..... April 29 1919

RANK, RATING ..... Pvt. Co G.

ORGANIZATION AND OUTFIT ..... 104th Infantry

SERVICE NUMBER 72725

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-303

be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. .....

Southboro, Mass
(City or Town making this return)

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)

No. Fatal Highway Accident Rte 30 St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert Forsyth Scharges
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) None

Teacher
(a) Residence. No. Fay School, Southboro, Mass. St. 302 96th St. Broklynn 9, N.Y.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 4 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Accidental death in automobile accident causing multiple injuries including skull fracture and brain injuries.

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury 11:20 PM 1-4 1965
IF ACCIDENTAL, was injury causally related to the death? Yes
Where did Injury occur? Southboro Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Public Street
(Specify type of place)
Manner of Injury Car (he was driving) Struck Tree
(How did injury occur?)
Nature of Injury Fracture of Skull and brain injury
While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) S. Alden Guild M.D.
S. Alden Guild MD
(Print or Type Name)
(Address) Gratton Date 1-5 1965

7 Greenwood Cemetery Brooklyn N.Y.
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL Jan. 8, 1965

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed January 7, 1965
Clarence F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M

10 COLOR White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Single

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE 26 Years 6 Months 7 Days
If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Teacher Fay School
(Kind of work done during most of working life)

15 Industry or Business: Fay School Southboro, Mass

16 Social Security No. 044-28-2364

17 BIRTHPLACE (City) Brooklyn
(State or country) N.Y.

PARENTS

18 NAME OF FATHER Horatio W. Scharges

19 BIRTHPLACE OF FATHER (City) Brooklyn
(State or country) N.Y.

20 MAIDEN NAME OF MOTHER Margaret Forsyth

21 BIRTHPLACE OF MOTHER (City) Stevenson
(State or country) Maryland

22 Informant Horatio W. Scharges
(Address) 302 96th St Brooklyn, N.Y.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Simon A Tourkow
(Signature of Agent of Board of Health or other)

(Official Designation) 1/5/65 (Date of Issue of Permit)

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

—

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli-ions which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the under-lying cause last.

Conditions contrib-ing to death but not ated to the terminal ease condition given (a).

491
90

uneral Director
Please use only
BLACK Ink.

DH 2-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 00237

PLACE OF DEATH

1 OUT OF - TOWN
SUFFOLK (County)
BOSTON (City or Town)
Massachusetts General Hospital PHILLIPS HOUSE
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Helen Haynes Burnett
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. ..... Main ..... St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 6, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 5, 1965, to January 6, 1965
I last saw her alive on January 6, 1965, death is said to have occurred on the date stated above, at 9:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Bronchopneumonia	6 Days
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Pulmonary Emphysema	30 Yrs

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) C. E. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Jan. 6, 1965

6 Forest Hills Crematory Boston, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 8, 1965

7 NAME OF FUNERAL DIRECTOR J.S.Waterman & Sons
ADDRESS Boston, Mass.

Received and filed JAN 12 1965 19....
William J. Ware (Registrar)
Rec'd Jan. 27, 1965

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Female	White	Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Robert M. Burnett
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 84 Years 3 Months 28 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Framingham
(State or country) Mass.

PARENTS

17 NAME OF FATHER Daniel W. Haynes

18 BIRTHPLACE OF FATHER (City) Framingham
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Charlotte Farley

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) England

21 Informant Mrs. Mary Copeland
(Address)
Hotel Vendome, 160 Com. Ave., Boston Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Bellew 12729
(Signature of Agent of Board of Health or other)
(Official Designation)

June 7, 1965
(Date of Issue of Permit)

Eleanor F. Burke

70
FORM R-301

be filed for burial permit
with Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

OCM-9-63-93638

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

3 X

WORCESTER
(City or Town making this return)

Registered No. 77

1 PLACE OF DEATH: Worcester (County); Worcester (City or Town); No. St. Vincent Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lawrence Ellsworth (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. Valley Road St. Southboro, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 10 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1965, to January 10, 1965

I last saw him alive on January 10, 1965 death is said to have occurred on the date stated above, at 3:05A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Respiratory Insufficiency (PRIMARY) — days

Due To (b) Pulmonary Emphysema — 4 YEARS

Due To (c) —

OTHER SIGNIFICANT CONDITIONS Bronchial pneumania — days

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy & Clinic

5 Was disease or injury in any way related to occupation of deceased? Yes

If so, specify metal Grinder

(Signature) Thomas M. Fay, M. D.

Thomas M. Fay (Print or Type Name)

(Address) St. Vincent Hospital Date Jan. 10 1965

6 Glen Valley Cem. Barre — Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN. 12 1965

7 NAME OF FUNERAL DIRECTOR Richard P. Caldwell

ADDRESS 21 Cottage Ave. Marlboro

Received and filed JAN 12 1965

Robert J. O'Keefe (Registrar)

Feb. 12, 1965

A TRUE COPY ATTEST: Charles M. Callahan (T.D.)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of EUNICE ALENE (JASLIN) (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 74 Years 1 Months 14 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation MACHINIST (Kind of work done during most of working life)

14 Industry or Business LAPOINTE MACH. TOOL CO. HUDSON, MASS

15 Social Security No. 023-18-8733

16 BIRTHPLACE (City) (State or country) PETERBORO N.H.

PARENTS

17 NAME OF FATHER JOHN E. ELLSWORTH

18 BIRTHPLACE OF FATHER (City) BARRE (State or country) MASS

19 MAIDEN NAME OF MOTHER SUSIE T. HAIRE

20 BIRTHPLACE OF MOTHER (City) BARRE (State or country) MASS.

21 Informant MRS. CHARLOTTE McCULLOCH

(Address) VALLEY ST. SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

COMMISSIONER OF PUBLIC HEALTH (Official Designation)

JAN. 10, 1965 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-6-62-933104

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

4

Northborough
(City or Town making this return)

Registered No. 5

1 PLACE OF DEATH
Worcester (County)
Northboro (City or Town)
No. Green Acres Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lillian (Rouelle) Badger
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. Newton St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 5 years ..... months ..... days. In place of residence 18 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 25 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1959, to Jan. 25, 1965
I last saw him alive on Jan. 24, 1965 death is said to have occurred on the date stated above, at 5:35a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Septicemia — day
Due To (b) Pneumonitis — 3 days
Due To (c)
OTHER SIGNIFICANT CONDITIONS Cerebral Hemorrhage — 11 yrs.

Was autopsy performed? no
What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Timothy P. Stone, M. D.
(Address) Southboro, Mass. Date Jan. 25 1965

6 Wildwood Cemetery Ashland, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 27 1965

7 NAME OF FUNERAL DIRECTOR Carl E. Willson
ADDRESS 318 Union Avenue Framingham,

Received and filed February 5 1965
Edward F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Female	white	Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of George Badger
(Husband's name in full)

12 AGE 70 Years 1 Months 25 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired-Owner
(Kind of work done during most of working life)

14 Industry or Business: Badger Nursing Home-Framingham

15 Social Security No. 016-28-2019

16 BIRTHPLACE (City) (State or country) Vermont

PARENTS

17 NAME OF FATHER Charles Rouelle

18 BIRTHPLACE OF FATHER (City) (State or country) France

19 MAIDEN NAME OF MOTHER Jennie Emery

20 BIRTHPLACE OF MOTHER (City) (State or country) Vermont

21 Informant Mrs. Elizabeth Lenkner
(Address) 11 Audubon Rd. Framingham

A TRUE COPY
ATTEST: Marion B. Flynn
(Registrar of City or Town where death occurred)
DATE FILED January 25 1965

FORM R-301A

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 368

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. White Bagley Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frederick Luther Merton Morrill (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. White Bagley Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 23 years ..... months ..... days. In place of residence 23 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1959, requires Physicians to print or type name under signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 27 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10-24-64, to JANUARY 27, 1965. I last saw him alive on JANUARY 27, 1965, death is said to have occurred on the date stated above, at 3.10A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CANCER GENERALIZED METASTASIS — INTERVAL BETWEEN ONSET AND DEATH: 4 YRS

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) David R. Corey M.D., M. D.
(PRINT OR TYPE SIGNATURE)
(Address) Winter St. Holliston Date 1-28-1965

6 Place of Burial or Cremation: Rural Cemetery Southboro, Mass. (City or Town)
DATE OF BURIAL Jan 30. 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed February 1, 1965 19.....
Eleanor F. Burke (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed or divorced HUSBAND of Helen B. Webb (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 62 Years 5 Months 10 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Clergyman (Kind of work done during most of working life)

14 Industry or Business: Religion

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Georgetown Mass

PARENTS

17 NAME OF FATHER Harry D. Morrill

18 BIRTHPLACE OF FATHER (City) NewBrunswick (State or country) Canada

19 MAIDEN NAME OF MOTHER Estella Lamprey

20 BIRTHPLACE OF MOTHER (City) Hampton (State or country) N.H.

21 Informant (Address) Mrs. Helen B. Morrill White agley Rd Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Asst. Town Clerk Agent
(Signature of Agent of Board of Health or other)

(Official Designation) 1-29-65 (Date of Issue of Permit)

100M-6-59-925686

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 55

PLACE OF DEATH

1 Middlesex (County)

Marlborough (City or Town)

No. Braemoor Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bertha (Campbell) Keith (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR,) ----

(a) Residence. No. Turnpike Road (Usual place of abode) St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 16 days. In place of residence 21 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 26, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 4, 19 50, to February 26, 19 65

I last saw her alive on February 24 19 65 Death is said to have occurred on the date stated above, at 12:15p

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Coronary thrombosis — 8 days

Due To (b) Arteriosclerotic heart disease — 8 yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS hiatus hernia obesity cerebral thrombosis

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone, M. D.

(Address) Main Street Southboro, Mass Date Feb. 26 65

6 Place of Burial or Cremation Knollwood Memorial Park, Sharon, (City or Town) Mass

DATE OF BURIAL March 1 19 65

7 NAME OF FUNERAL DIRECTOR Eaton Funeral Home

ADDRESS Needham, Mass.

Received and filed March 4, 1965 19

(Registrar of City or Town where deceased resided)

March 8, 1965

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Married

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Currie Manning Keith

(Husband's name in full)

12 AGE 70 Years 11 Months 22 Days

If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housework (Kind of work done during most working life)

14 Industry or Business: Own home

15 Social Security No. -----

16 BIRTHPLACE (City) (State or country) Petticodiac New Brunswick

PARENTS

17 NAME OF FATHER John D. Campbell

18 BIRTHPLACE OF FATHER (City) Newtown (State or country) New Brunswick

19 MAIDEN NAME OF MOTHER Mimie Hope

20 BIRTHPLACE OF MOTHER (City) Fawcett (State or country) New Brunswick

21 Informant Claude O. Keith

(Address) 51 Norfolk St. Needham, Mass.

A TRUE COPY

ATTEST: Peter P. Cottone (Registrar of City or Town where death occurred)

DATE FILED March Agent Feb. 28, 1965 19

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); ..... (City or Town making this return)

No. Main Street, Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Edward Harlamert (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Main St. Southboro, Massachusetts (City or town and State)

Length of stay: In place of death 3 years ..... months ..... days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 4 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes: Coronary sclerosis
arteriosclerotic heart disease
(sudden death while on ladder at
home of employer)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) S. Alden Guild, M. D.

S. Alden Guild, M.D. (Print or Type Name)

(Address) Grafton Date ..... 19.....

Blue Hills Cemetery Braintree, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL March 6 19 65

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main Street, Southboro, Mass.

Received and filed April 26, 1965 19.....

A TRUE COPY ATTEST: Erma F. Burke (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
male	white	married

12 If married, widowed, or divorced
HUSBAND of Bessie Mae Green (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

13 AGE 61 Years 3 Months 11 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Maintenance (Kind of work done during most of working life)

15 Industry or Business: Business

16 Social Security No. 401-05-3199

17 BIRTHPLACE (City) St. Louis (State or country) Missouri

PARENTS

18 NAME OF FATHER Richard Harlamert

19 BIRTHPLACE OF FATHER (City) Louisville (State or country) Kentucky

20 MAIDEN NAME OF MOTHER Katherine Deters

21 BIRTHPLACE OF MOTHER (City) Louisville (State or country) Kentucky

22 Informant Leroy Harlemert
(Address) 746 Beechmont Street
Hyde Park, Massachusetts

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

..... (Signature of Agent of Board of Health or other)

..... (Official Designation) (Date of Issue of Permit)

MEDICAL

M R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

1 PLACE OF DEATH: WORCESTER (County) GRAFTON Southboro (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

No. Main Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME George (First Name) Edward (Middle Name) Harlamert (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. Main Street St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years ..... months ..... days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 4 (Day) 1965 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Under investigation

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury 10.00A.M. 3/4/1965
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? Southboro, Mass. (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Residence (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? Yes Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) S. Alden Gould, M. D.
S. ALDEN GOULD M.D. (Print or Type Name)
(Address) Grafton Date 4 Mar 1965

7 Blue Hills Cemetery Braintree Mass
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL March 6, 1965

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main St. Southboro, Mass.

Received and filed March 8, 1965
(Registrar)
A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
M	White	YES ☒ NO ☐	MARRIED ☒

12a If married, widowed, or divorced
HUSBAND of Bessie Mae Green (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 DATE OF BIRTH Nov. 23, 1903

14 AGE 61 Years 3 Months 11 Days — If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Maintenance (Kind of work done during most of working life)

16 Industry or Business: Business

17 Social Security No. 401-05-3199

18 BIRTHPLACE (City) St. Louis (State or country) Mo.

PARENTS

19 NAME OF FATHER Richard Harlamert

20 BIRTHPLACE OF FATHER (City) Louisville (State or country) Ky.

21 MAIDEN NAME OF MOTHER Katherine Deters

22 BIRTHPLACE OF MOTHER (City) Louisville (State or country) Ky

23 Informant Leroy Harlamert
(Address) 746 Beechmont St Hyde Park Mas

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Sara A. Tocalett Asst.
(Signature of Agent of Board of Health or other)

(Official Designation) March 5 - 1965 (Date of Issue of Permit)

MEDICAL

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

7

Framingham
(City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna Maude Piper (Rafford)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Southville Road St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 12 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 7, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 6, 1965, to March 7, 1965

I last saw her alive on March 6, 1965

Death is said to have occurred on the date stated above, at 7:30am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: yrs.

Due To
(b) .....

Due To
(c) .....

OTHER SIGNIFICANT CONDITIONS Fracture right tibia — 1 dy.

Was autopsy performed? no

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Richard E. Senghas, M. D.

(Address) Framingham Date 3/7/65

6 Evergreen Cem. Houlton, Maine
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Entombment 3/10/65 19.....

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed MAR 17 1965 19.....

Eleanor J. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James W. Piper
(Husband's name in full)

12 AGE 99 Years 2 Months 3 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. none

16 BIRTHPLACE (City) Houlton, Maine
(State or country)

PARENTS

17 NAME OF FATHER Osbert Rafford

18 BIRTHPLACE OF FATHER (City) Houlton, Maine
(State or country)

19 MAIDEN NAME OF MOTHER Melissa Holden

20 BIRTHPLACE OF MOTHER (City) Houlton, Maine
(State or country)

21 Informant Mrs. Marjorie Kennedy
(Address) Southville Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Blake
(Registrar of City or Town where death occurred)

DATE FILED March 10 1965

50M-6-62-933104

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Middlesex (County)

Framingham (City or Town)

No. 228 Concord St., St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harriet Kaler (Hodge)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. East Main St., St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 2 years.....months.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 22 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Mar 22, 19 65, to March 22, 19 65.
I last saw her alive on March 22, 19 65. Death is said to have occurred on the date stated above, at 4 am m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 3-4hrs

Due To (b) Thrombophlebitis lt leg — dys.

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS Generalized arteriosclerosis — yrs.

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) John F. Whitcomb, M. D.

(Address) Framingham Date 3/22/ 65

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 24 65

7 NAME OF FUNERAL DIRECTOR Carl E. Willson

ADDRESS Framingham, Mass.

Received and filed APR 9 1965 19.....

Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
female	white	divorced

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Robert H. Kaler
(Husband's name in full)

12 AGE 81 Years 3 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 022-07-5643

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER Roswell B. Hodge

18 BIRTHPLACE OF FATHER (City) (State or country) Vermont

19 MAIDEN NAME OF MOTHER Adline Culver

20 BIRTHPLACE OF MOTHER (City) (State or country) Vermont

21 Informant Ida M. Kaler
(Address) 18 Shawmut Terrace Framingham, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED April 2, 1965 19.....

50M-6-62-933L04

.305

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10

PLACE OF DEATH

1 Middlesex (County)

Marlborough (City or Town)

Marlborough (City or Town making this return)

Registered No. .....

No. D.O.A. Marlboro Hospital St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Leo A. Bertonazzi
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. School St. Southborough, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 1, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Laceration brain, fracture right maxilla, fracture skull

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury 11:00p.m./4-1- 19 65

IF ACCIDENTAL, was injury causally related to the death? yes

Where did Injury occur? Marlboro
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Public
(Specify type of place)

Manner of Injury Auto accident
(How did injury occur?)

Nature of Injury Head trauma

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify Autopsy ordered by D.A.'s office on 4-2-65

(Signed) Kenneth R. Greenleaf, M. D.

(Address) Marlboro, Mass. Date Apr. 1 19 65

7 Rural Cemetery, Southboro, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL April 5 19 65

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed April 8 65

Clarence T. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Male	White	Single

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE 24 Years 4 Months 9 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Caretaker & construction
(Kind of work done during most of working life)

15 Industry or Business: Cemetery & Industry

16 Social Security No. 013-36-7289

17 BIRTHPLACE (City) (State or country) Marlborough, Mass.

PARENTS

18 NAME OF FATHER Leo Bertonazzi

19 BIRTHPLACE OF FATHER (City) Sherbon (State or country) Mass

20 MAIDEN NAME OF MOTHER Rita B. Monette

21 BIRTHPLACE OF MOTHER (City) Marlborough (State or country) Mass

22 Informant (Address) Leo Bertonazzi - father School St. Southboro, Mass.

A TRUE COPY Rita A. Lapsine

ATTEST: Peter P. Cotrone
(Registrar of City or Town where death occurred)

Agent

DATE FILED April 3, 1965

50M-3-62-932695

The [illegible] as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

3 A

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

No. Tara Drive St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Cecil (First Name) L. (Middle Name) Stiffler (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence. No. Tara Drive St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 6 months ..... days. In place of residence 1 years 6 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 5 (Day) 1965 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease; Presumably coronary occlusion (Sudden death)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) S. Alden Guld, M. D.
S. ALDEN GULD M.D.
(Print or Type Signature)

(Address) Grafton Mass. Date Apr. 6 19 65

7 Rural Cemetery Southboro, Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 8, 19 65

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed April 7, 19 65

Eleanor S. Burbank
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

11a If married, widowed, or divorced HUSBAND of Edith E. Forbes
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 49 Years 4 Months 3 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: New Products Planner
(Kind of work done during most of working life)

15 Industry or Business: General Electric

16 Social Security No. 275-18-1791

17 BIRTHPLACE (City) Columbus (State or country) Ohio

PARENTS

18 NAME OF FATHER Hugh F. Stiffler

19 BIRTHPLACE OF FATHER (City) Wellston (State or country) Ohio

20 MAIDEN NAME OF MOTHER Rebecca Ann Paugh

21 BIRTHPLACE OF MOTHER (City) Clarksburg (State or country) West Virginia

22 Informant (Address) Edith E. Stiffler, Tara Dr Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Anna Susan Toscano
(Signature of Agent of Board of Health or other)

(Official Designation) 4-7-65 (Date of Issue of Permit)

50M-6-60-928145

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

.ONAL INFORMATION .....

RING MILITARY SERVICE ..... March 27, 1942 .....

CHARGE ..... Nov. 6, 1945 .....

NG ..... Corpral .....

.TION AND OUTFIT Hdqtrs Btry 211th F.A. Bn. .....

NUMBER ..... 35 291 761 .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

943

ORM R-303

e filed for burial permit
ith Board of Health
or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 34, §§ 6, 26; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

K 12

PLACE OF DEATH

1 Worcester (County)
Worcester (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WORCESTER (City or Town making this return)
Registered No. 968

No. St. Vincent Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lea Colle He (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parkerville Rd St. Southboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 24 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 10 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

arteriosclerotic heart disease

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury pm March 17 1965

IF ACCIDENTAL, was injury causally related to the death? yes

Where did Injury occur? Southboro Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? home (Specify type of place)

Manner of Injury fell in room (How did injury occur?)

Nature of Injury fracture right hip

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John C Ward, M. D.

(Print or Type Name) JOHN C WARD

(Address) 955 Main St Date April 11 1965

7 NOTRE DAME WORCESTER MA
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL APRIL 14 1965

8 NAME OF FUNERAL DIRECTOR DONALD C MORRIS

ADDRESS MAIN ST SOUTHBORO MASS

Received and filed APR 12 1965 19

Robert J. O'Keefe (Registrar)

A TRUE COPY ATTEST: Apr 1 1965

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
F	WHITE	MARRIED

12 If married, widowed, or divorced
HUSBAND of
(or) WIFE of FERDINAND COLLETTE (Give maiden name of wife in full) (Husband's name in full)

13 AGE 83 Years 3 Months 11 Days — If under 24 hours: Hours Minutes

14 Usual Occupation: HOUSE WIFE (Kind of work done during most of working life)

15 Industry or Business: HOME

16 Social Security No.

17 BIRTHPLACE (City or State or country) DUDLEY MASS

PARENTS

18 NAME OF FATHER JOSEPH LABARRE

19 BIRTHPLACE OF FATHER (City) Cannot be learned (State or country) CANADA

20 MAIDEN NAME OF MOTHER SOPHINA FORAND

21 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country) CANADA

22 Informant FERDINAND COLLETTE (Address) PARKERVILLE RD SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joan McGinnis (Signature of Agent of Board of Health or other)
Clerk
COMMISSIONER OF PUBLIC HEALTH

Apr 11/65 (Official Designation) (Date of Issue of Permit)

MEDICAL

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-6-62-933104

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

13

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Herbert E. Harrington (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WWI&II

(a) Residence. No. Main (Usual place of abode) St. Southboro (City or town and State)

Length of stay: In place of death 0 years 0 months 4 days. In place of residence 30 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 11, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Mar. 8, 1948 to May 11, 1965

I last saw him alive on May 10, 1965, death is said to have occurred on the date stated above, at 7:30a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Hepatoma	?2 Mos.
Due To (b)	Cirrhosis	--
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Peptic ulcers, bleeding	1 Yr. Terminal

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date May 11 1965

6 Rural Cem., Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 13, 1965

7 NAME OF FUNERAL DIRECTOR Charles W. Dee

ADDRESS Concord, Mass.

Received and filed JUN 2 1965

Eleanor F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Widowed

11 If married, widowed, or divorced
HUSBAND of Ruth Wilbur (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 68 Years 6 Months 7 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: U. S. Navy (Kind of work done during most of working life)

14 Industry or Business: Lt. Commander

15 Social Security No. 011-36-0524

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Herbert Harrington

18 BIRTHPLACE OF FATHER (City) (State or country) CNBL

19 MAIDEN NAME OF MOTHER Elizabeth Cook

20 BIRTHPLACE OF MOTHER (City) (State or country) CNBL

21 Informant Victoria Loring
Lowell Rd.
(Address) Concord, Mass.

A TRUE COPY
ATTEST: Michael J. Ford (Registrar of City or Town where death occurred)

DATE FILED May 18, 1965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE July 30, 1942

DATE OF DISCHARGE Nov. 28, 1954

RANK, RATING Lt. Commander

ORGANIZATION AND OUTFIT U. S. Navy

SERVICE NUMBER 12682

RULES OF PRACTICE

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(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-6-62-933104

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Boy Bean (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Oak Hill Rd., St. Southboro, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months 1 days. In place of residence.....years.....months 1 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 23 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 23, 1965, to May 23, 1965. I last saw him alive on May 23, 1965, death is said to have occurred on the date stated above, at 5pm m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Hyaline membrane disease	10 hrs.
Due To (b)	Prematurity-wt. 2lbs. 10 oz.	10 hrs.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) John S. Taub, M.D., M. D.

(Address) Framingham Date 5/23/65 19

6 St. Stephen Cemm Framingham Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 25 65

7 NAME OF FUNERAL DIRECTOR Lawrence Volpe, Jr.

ADDRESS Framingham, Mass.

Received and filed JUN 2 1965 19

Eleanor T. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
ml male	white	single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE Years Months 1 Days | If under 24 hours Hours Minutes

13 Usual Occupation: .....
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

17 NAME OF FATHER: Howard A. Bean

18 BIRTHPLACE OF FATHER (City) Portland, (State or country) Maine

19 MAIDEN NAME OF MOTHER: Mary Brook

20 BIRTHPLACE OF MOTHER (City) Louisville, (State or country) Kentucky

21 Informant Howard Bean

(Address) Oak Hill Rd. Southboro, Mass.

A TRUE COPY

ATTEST: Michael J. Ward (Registrar of City or Town where death occurred)

DATE FILED May 25 1965

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

15

Framingham
(City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth Forbes (Cuthbert)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. 1 Tara Rd., St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 19 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 8, 1965, to June 19, 65
I last saw her alive on June 19, 1965, death is said to have occurred on the date stated above, at 12:01 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Staphyloccal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 dys

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Chronic Peylonephritis — yrs.

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Clarence Brown., M. D.

(Address) Natick, Mass. Date 6/19/65

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 21 65

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed JUN 28 1965

Leonna F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Frank D. Forbes
(Husband's name in full)

12 AGE 74 Years 7 Months 10 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. 030-18-5042

16 BIRTHPLACE (City) England
(State or country)

PARENTS

17 NAME OF FATHER Frederick Cuthbert

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Mary A. Raglan

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant Mrs. Edith E. Stiffler

(Address) 1 Tara Road Southboro, Mass.

A TRUE COPY

ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED June 22 1965

50M-6-62-933L04

ORM R-302

— WHITE UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 169

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Marlboro Hospital (If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

Marlborough (City or Town making this return)

2 FULL NAME Charles B. Charest (If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR,) no

(a) Residence. No. Parkerville Road St. Southborough, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 1 day. In place of residence 40 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 4, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1965, to July 4, 1965.

I last saw him alive on June 30, 1965 death is said to have occurred on the date stated above, at 8:30p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Adenocarcinomatosis	6 mos
Due To (b)	Ca Stomach	2 yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? no

What test confirmed diagnosis? Biopsy & X-ray

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify no

(Signed) John Paul Ahearn, M. D.
14 Winthrop St.

(Address) Marlboro, Mass. Date July 4, 1965

6 Place of Burial or Cremation: Rural Cemetery, Southboro, Mass. (City or Town)

DATE OF BURIAL July 7 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Main St. Southboro, Mass.

Received and filed July 8 1965

August 13, 1965 F. Burke Agent

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	married

11 If married, widowed, or divorced
HUSBAND of Lillian Morin (Wife's name in full)
(or) WIFE of ....(Husband's name in full)

12 AGE 70 Years 1 Months 12 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Farmer (Kind of work done during most working life)

14 Industry or Business: Chickens & Garden produce

15 Social Security No. 010-30-6846

16 BIRTHPLACE (City) (State or country) Matane, Canada

PARENTS

17 NAME OF FATHER Elzear Charest

18 BIRTHPLACE OF FATHER (City) Matane (State or country) Canada

19 MAIDEN NAME OF MOTHER Delphine Cote

20 BIRTHPLACE OF MOTHER (City) Matane (State or country) Canada

21 Informant (Address) Mrs. Lillian Charest- wife
Parkerville Rd. Southboro, Mass

A TRUE COPY Rita A. Lapsire

ATTEST: Peter P. Cotone (Clerk or City Council of city where death occurred)

FILED July 5, 1965

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-6-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Donn Walden (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Clemmons St., St Southboro, Mass. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 1 years 6 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 29 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 29, 1965, to July 29, 65

I last saw him alive on July 29, 1965 death is said to have occurred on the date stated above, at 4:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Acute myocardial infarction — 18 hrs.

Due To (b) Atherosclerotic heart disease — 3 yrs.

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signature) George Cytroen, M. D.

(Address) Framingham Date 7/30/65

6 Rural Cem., Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 2, 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed August 27, 1965

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
male	white	married

11 If married, widowed, or divorced
HUSBAND of Elizabeth Hedges (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 40 Years 6 Months 28 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Sales Executive (Kind of work done during most of working life)

14 Industry or Business: General Motors Chevrolet

15 Social Security No. 521-18-3662

16 BIRTHPLACE (City) Denver, (State or country) Colorado

PARENTS

17 NAME OF FATHER Ransom Post Walden

18 BIRTHPLACE OF FATHER (City) St. Louis, (State or country) Mo.

19 MAIDEN NAME OF MOTHER Alice B. McCanna

20 BIRTHPLACE OF MOTHER (City) DesMoines, (State or country) Iowa

21 Informant Mrs. Elizabeth Walden

(Address) Clemmons St., Southboro, Mass.

A TRUE COPY

ATTEST: Michael J. Ward

(Registrar of City or Town where death occurred)

DATE FILED August 4, 1965

FORM R-302

MARGIN RESERVED FOR BINDING

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19

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anne Viola Lynch (Fors)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Permanent Residence. No. Oak Hill Road St. Southboro, Mass. (City or town and State)

Length of stay: In place of death 1 years 20 months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 2 (Day) 1965 (Year)

4 I HEREBY CERTIFY That I attended deceased from June 13, 1965, to August 2, 1965

I last saw her alive on August 1, 1965, death is said to have occurred on the date stated above, at 1:10am m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Carcinoma of ovary — 6 mons.

Due To (b) .....

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS: Broncho pneumonia — 3 dys.

Was autopsy performed? no

What test confirmed diagnosis? Surgical biopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Herbert M. Levenson, M. D.

(Address) Framingham Date 8/2/65 19.....

6 Edgell Grove Cem., Framingham
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 3 1965

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth

ADDRESS Framingham, Mass.

Received and filed August 27, 1965 19.....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of George W. Lynch
(Husband's name in full)

12 AGE 53 Years 9 Months 20 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housework
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Sweden

PARENTS

17 NAME OF FATHER Leonard S. Fors

18 BIRTHPLACE OF FATHER (City) (State or country) Sweden

19 MAIDEN NAME OF MOTHER Charlotte Jonsson

20 BIRTHPLACE OF MOTHER (City) (State or country) Sweden

21 Informant George W. Lynch
(Address) Oak Hill Road Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Wade
(Registrar of City or Town where death occurred)

DATE FILED August 4, 1965

100M-3-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Maria Giombetti (Finnochi) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Cordaville Road St. Southboro (City or town and State)

Length of stay: In place of death.....years.....months 23 days. In place of residence 44 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 9, (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 20, 1965, to August 9, 1965

I last saw her alive on August 8, 65, death is said to have occurred on the date stated above, at 7 am m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral thrombosis	5 dys.
Due To (b)	Arteriosclerosis generalized	2 yrs.
Due To (c)	Diabetes mellitus	5 yrs.
OTHER SIGNIFICANT CONDITIONS	Gangerene left foot	8 mons.

Was autopsy performed? no

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signature) Lee Gordon Kendall, M.D., M. D.

(Address) Framingham Date 8/9/65 19.....

6 Rural Cem., Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 11 65

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed August 27, 1965 19.....

Florence F. Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	married

11 If married, widowed, or divorced

HUSBAND of .....

(Give maiden name of wife in full)

(or) WIFE of Antonio Giombetti

(Husband's name in full)

12 AGE 72 Years 6 Months 18 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Luigi Finnochi

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Rusini Giocomina

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Antonio Giombetti

(Address) Cordaville Rd., Southboro, Mass.

A TRUE COPY

ATTEST: Michael J. Ward

(Registrar of City or Town where death occurred)

DATE FILED August 10 1965

100M-5-61-9-8000

ORM R-302

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

17

(City or Town receiving this return) Milford

Registered No. .....

1 PLACE OF DEATH: Worcester (County) / Milford (City or Town)

No. Milford Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ----- Sweeney
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 9 Oregon Rd. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 6hrs. days. In place of residence ..... years ..... months 6hrs. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 11 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1965, to August 11, 1965
I last saw him alive on August 11, 1965 death is said to have occurred on the date stated above, at 2:45p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hyalin Membrane Disease — INTERVAL BETWEEN ONSET AND DEATH: -

Due To
(b) Prematurity — -

Due To
(c) -

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? Yes
What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) John D. Alden, M. D.

(Address) 114 Water St. Milford, Mass. Date 8/12 1965

Place of Burial or Cremation St. Patrick's Natick (City or Town)

DATE OF BURIAL August 13 1965

7 NAME OF FUNERAL DIRECTOR John Everett & Son

ADDRESS Natick, Mass. Wm. P. Everett

Received and filed August 16 1965

Chauncey F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Male	White	Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE ..... Years ..... Months ..... Days — If under 24 hours: 6 Hours ..... Minutes

13 Usual Occupation: -
(Kind of work done during most working life)

14 Industry or Business: -

15 Social Security No. -

16 BIRTHPLACE (City) (State or country) Milford Mass.

PARENTS

17 NAME OF FATHER James Sweeney

18 BIRTHPLACE OF FATHER (City) (State or country) Natick Mass.

19 MAIDEN NAME OF MOTHER Helen Soule

20 BIRTHPLACE OF MOTHER (City) (State or country) Attleboro Mass.

21 Informant James Sweeney
(Address) 9 Oregon Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Catherine L. Coyne
(Registrar of City or Town where death occurred)

DATE FILED August 13 1965

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

21

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Rabeni (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Central St., St. Southboro, Mass. (City or town and State)

Length of stay: In place of death.....years 1 months 1 days. In place of residence 60 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 18 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1965, to August 18, 1965

I last saw him alive on August 17, 1965, death is said to have occurred on the date stated above, at 8:30am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Congestive heart failure — 3 mons

Due To (b) Arteriosclerotic heart failure — 3 yrs.

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Was autopsy performed? yes

What test confirmed diagnosis? above

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) John F. Whitcomb, M. D.

(Address) Framingham Date 8/18/65 19

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 21 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed August 27, 1965 19

Clarence J Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
male	white	widowed

11 If married, widowed or divorced HUSBAND of Josephine Aspesi (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 83 Years 10 Months 4 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Landscape gardner (Kind of work done during most of working life)

14 Industry or Business: Private

15 Social Security No. 017-16-9386

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER John Rabeni

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Maria Peratti

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant John J. Rabeni

(Address) Central St., Southboro, Mass.

A TRUE COPY Michael J. Ward

ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED August 23, 1965 19

100M-7-64-938000

FORM R-361

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

ON-12-62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

PLACE OF DEATH

1 (County) Suffolk
(City or Town) Brighton
No. Hahnemann Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

(City or Town making this return)

Registered No. 08387

PHYSICIAN — IMPORTANT

2 FULL NAME Miss Nora F Roche
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, (if so specify WAR).....)

(a) Residence. No. 30 Jericho Hill Rd (Usual place of abode) Southboro Mass (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 8 (Month) 22 (Day) 65 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 4/27, 1964, to 8/22, 1965

I last saw him alive on 8-22-, 1965 death is said to have occurred on the date stated above, at 7.30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Breast — INTERVAL BETWEEN ONSET AND DEATH 10 years

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Robert D Sullivan, M. D.
(Print or Type Name)

(Address) Lahey Clinic Boston Date 8/23/65

6 Immaculate Conception Marlboro Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug 26 1965

7 NAME OF FUNERAL DIRECTOR John W. Sullivan

ADDRESS 37 F Lincoln Marlboro

Received and filed AUG 24 1965

William J. Shaw (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Single

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 71 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation Retired Secretary (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 017-28-6149

16 BIRTHPLACE (City) (State or country) Southboro Mass

PARENTS

17 NAME OF FATHER Martin Roche

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Nora Gilboyle

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Mr John Roche Brother

(Address) Jericho Hill Rd Southbo

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Eugene Rogers C 14635
(Signature of Agent of Board of Health or Other) (Official Designation)

August 23 1965
(Date of Issue of Permit)

A TRUE COPY ATTEST: November 26, 1965

Eleanor F. Burke

v #2115

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WORCESTER
(City or Town making this return)

Registered No. 2185

PLACE OF DEATH

1 Worcester (County)

Worcester (City or Town)

No. Hahnemann Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ~~Mrs~~ Elizabeth Prosperi (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 78 Newton Street (Usual place of abode) St. Southboro (City or town) Mass. (State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT (Month) 1 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUG 20, 1965, to SEPT 1, 1965

I last saw him alive on SEPT 1, 1965, death is said to have occurred on the date stated above, at 9:25 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

Due To (b) ARTERIO SCLEROTIC HEART DIS — YRS

Due To (c)

OTHER SIGNIFICANT CONDITIONS OBESITY

Was autopsy performed? NO

What test confirmed diagnosis? CLIN

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) L. A. Fundy, M. D.

(Print or Type Name) L A FUNDY

(Address) 32 FRANKLIN Date SEPT 2 1965

6 RURAL CEM SOUTHBORO MASS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT 4 1965

7 NAME OF FUNERAL DIRECTOR DONALD C. MORRIS

ADDRESS 40 MAIN ST SOUTHBORO MASS

Received and filed SEP 8 1965 19

Robert J. O'Keefe (Registrar)

Rec'd October 20, 1965

A TRUE COPY ATTEST: Clarence F. Burke

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
F	WHITE	MARRIED

11 If married, widowed, or divorced
HUSBAND of
(or) WIFE of LOUIS PROSPERI (Give maiden name of wife in full) (Husband's name in full)

12 AGE 68 Years 0 Months 21 Days — If under 24 hours: Hours Minutes

13 Usual Occupation: HOUSE WIFE (Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) PESARO ITALY

PARENTS

17 NAME OF FATHER PETER MAGI

18 BIRTHPLACE OF FATHER (City) PESARO (State or country) ITALY

19 MAIDEN NAME OF MOTHER ANGELINE GASTANZ

20 BIRTHPLACE OF MOTHER (City) PESARO (State or country) ITALY

21 Informant LOUIS PROSPERI

(Address) 78 NEWTON ST SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death has been filed with me and that the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

COMMISSIONER OF PUBLIC HEALTH

(Official Designation) (Date of Issue of Permit) 9/3/65

15

100M-6-62-93404

2143

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

INT OR TYPE
ISE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
mode of dying,
as heart failure,
sis, etc. It means
disease, or compli-
ns which caused
h.

nditions, if any,
hich gave rise to
ove cause (a),
ting the under-
ing cause last.

Conditions contrib-
to death but not
ed to the terminal
se condition given
).

79
-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

24 X

WORCESTER
(City or Town making this return)

Registered No. 2220

PLACE OF DEATH
1 Worcester (County)
Worcester (City or Town)
No. St. Vincent Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME (Reverend) Henry Frederick Murphy
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WARs)

(a) Permanent Residence. No. St. Anne's Rectory St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death ....years 1 months 10 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 6 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 27, 1965 to September 6, 1965
I last saw him alive on Sept. 6, 1965 death is said to have occurred on the date stated above, at 1:50P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 dys
Due To (b)
Due To (c)
OTHER SIGNIFICANT CONDITIONS: Metastatic Carcinoma of Prostate (seat prostate) 1 yr

Was autopsy performed? no
What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) Robert E Bessette, M. D.
Dr. Robert E. Bessette
(Print or Type Name)
(Address) St. Vincent Hosp. Date 9/6 1965

6 Calvary Cem. Greenfield, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 9, 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Main Street, Southboro, Mass.

Received and filed SEP 13 1965 19....
Robert J. O'Keefe
Rec'd October 20, 1965 (Registrar)
A TRUE COPY ATTEST: Theresa T. Burke

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
male	white	single

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

12 AGE 70 Years 5 Months 10 Days — If under 24 hours: ....Hours ....Minutes

13 Usual Occupation Catholic Priest
(Kind of work done during most of working life)

14 Industry or Business: Religious life

15 Social Security No. ....

16 BIRTHPLACE (City) Greenfield (State or country) Mass.

PARENTS

17 NAME OF FATHER John H. Murphy

18 BIRTHPLACE OF FATHER (City) Greenfield (State or country) Mass.

19 MAIDEN NAME OF MOTHER Ellen McAuliffe

20 BIRTHPLACE OF MOTHER (City) Greenfield (State or country) Mass.

21 Informant Miss Pauline Murphy
(Address) Greenfield, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death has been filed with me and that burial or transit permit was issued:

Howard M. Simms
(Signature of Agent of Board of Health or other)
COMMISSIONER OF PUBLIC HEALTH
(Official Designation) (Date of Issue of Permit) 9/8/65

FORM R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 22

No. U.S. Govt. Post Office St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward (First Name) B (Middle Name) Waite Jr. (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence. No. Lajeune Lodge Turnpike Rd St. Southboro, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death Postmaster 5 years ..... months ..... days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept (Month) 16 (Day) 1965 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Self-inflicted gun shot wound of the head

5 Accident, suicide, or homicide (specify) Suicide

Date and hour of injury AM 9-16 19 65

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) S. Alden Gould M.D.

S. ALDEN GOULD M.D. (Print or Type Name)

(Address) Grafton Date 9-16 1965

7 Rural Cemetery Southboro, Mass
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Sept. 19, 1965 19

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St Southboro, Mass

Received and filed September 22, 19 65

Donna F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☒ UNKNOWN ☐
M	White	YES ☒ NO ☐	

12a If married, widowed, or divorced
HUSBAND of Gladys Dunn (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH October 30, 1916 (1916)

14 AGE 47 Years 10 Months 16 Days | If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: U.S. Postmaster (Kind of work done during most of working life)

16 Industry or Business: U.S. Post Office

17 Social Security No.

18 BIRTHPLACE (City) Millbury (State or country) Mass

PARENTS

19 NAME OF FATHER Edward B. Waite Sr

20 BIRTHPLACE OF FATHER (City) Newton (State or country) Mass

21 MAIDEN NAME OF MOTHER Cora Harvey

22 BIRTHPLACE OF MOTHER (City) Southboro (State or country) Mass

23 Informant Mrs. Jean McLaughlin
(Address) E. Main St. Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) September 18 1965 (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ....August 15, 1942.....

DATE OF DISCHARGE ..December 1, 1945.....

RANK, RATING ..C..P..O..?.....

ORGANIZATION AND OUTFIT ....USN.....

SERVICE NUMBER .....706 30 37.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

23

COPY OF CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 249

PLACE OF DEATH

1 Middlesex (County)

Marlborough (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rideo Giombetti (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR,) no

(a) Residence. No. Cordaville Road (Usual place of abode) St. Southborough, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 4 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 7, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1965, to October 7, 1965

I last saw him alive on October 7, 1965 death is said to have occurred on the date stated above, at 7.00p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CO_2 Narcosis	3 das
Due To (b) Sclerosing mediastinitis	5 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Pulmonary emphysema	5 yrs

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) J. Lawrence Dohan, M. D.

(Address) Hudson, Mass Date Oct. 7 1965

6 Rural Cemetery, Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 11 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed October 13 1965

Rita A. Lahue (Registrar of City or Town where deceased resided)

Edmund F. Burke

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Male	White	Single

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 50 Years 7 Months 21 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Shoe worker (Kind of work done during most working life)

14 Industry or Business: Diamond Shoe Co.

15 Social Security No. 024-09-2944

16 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

17 NAME OF FATHER Antonio Giombetti

18 BIRTHPLACE OF FATHER (City) Mondolfo (State or country) Italy

19 MAIDEN NAME OF MOTHER Maria Finocchi

20 BIRTHPLACE OF MOTHER (City) Mondolfo (State or country) Italy

21 Informant Antonio Giombetti (Address) Cordaville, Rd. Southboro, Mas

A TRUE COPY

ATTEST: Peter P. Cottone (Registrar of City or Town where death occurred)

DATE ISSUED Agent Oct. 8, 1965

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas O'Brien (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Permanent Residence. No. Turnpike Road St. Southboro (City or town and State)

Length of stay: In place of death ..... years ..... months 6 days. In place of residence 24 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 19 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19 58, to Oct 19, 65

I last saw him alive on October 19 65, 19 ....., death is said to have occurred on the date stated above, at 4:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Hypernephroma left kidney — 8-12 mos

Due To (b) Hemorrhage & obstruction — 2 wk

Due To (c) similar tumor rt. 1958 (nephrectomy) — 8 yrs

OTHER SIGNIFICANT CONDITIONS Uremia Congestive failure

Was autopsy performed? no

What test confirmed diagnosis? X-ray, pyelogram

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signature) William H. Holtham, M. D.

(Address) Framingham Date 10/19/65 19

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 22 65 19

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed November 15, 1965 19

Eleanora T. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	white	married

11 If married, widowed, or divorced
HUSBAND of Emma Trioli (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 77 Years 9 Months 1 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Paper Box Mfg. (Kind of work done during most of working life)

14 Industry or Business: Dennison Mfg. Co.

15 Social Security No. 019-10-1678

16 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

17 NAME OF FATHER John O'Brien

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Bridget Porter

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Mrs. Thomas P. O'Brien
(Address) Turnpike Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED October 21, 1965 19

100M-5-61-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... March 19, 1918

DATE OF DISCHARGE ..... January 15, 1919

RANK, RATING .....

ORGANIZATION AND OUTFIT ..... ASFS Squadron "B" AS (A) Reg Army

SERVICE NUMBER 1115896

.....

R-303

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 26

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dougherty, Raymond F.
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence, No. Marlboro Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 25 years ..... months ..... days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 23 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Natural causes: Coronary artery disease presumably myo-cardial infarction (Sudden death)

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
(How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) S. Alden Budd M.D., M. D.
S. Alden Budd M.D.
(Print or Type Name)
(Address) Grafton Date Oct 23 1965

7 St. Michaels Hudson, Mass.
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL October 26, 1965

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS 40 Main St Southboro Mass.

Received and filed October 27 1965
Rosanna F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
M	White	YES ☒ NO ☐	

12a If married, widowed, or divorced
HUSBAND of Rose Blanchette
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 DATE OF BIRTH June 2, 1896

14 AGE 69 Years 4 Months 21 Days. If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Machinist & Tool Maker
(Kind of work done during most of working life)

16 Industry or Business: Dougherty Tool Co.

17 Social Security No. 011-05-3254

18 BIRTHPLACE (City) (State or country) Pawtucket R.I.

PARENTS

19 NAME OF FATHER John Dougherty

20 BIRTHPLACE OF FATHER (City) (State or country) CNBL Ireland

21 MAIDEN NAME OF MOTHER Peggy O'Neil

22 BIRTHPLACE OF MOTHER (City) (State or country) CNBL Ireland

23 Informant (Address) Mrs. Raymond F. Dougherty Marlboro Road, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Jean Sinclair Tocchetti
(Signature of Agent of Board of Health or other)
(Official Designation)
10-25-65
(Date of Issue of Permit)

MEDICAL

DECLARATION should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

27

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Marlborough
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. 265

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Braemoor Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hester Belle (Peacock) Stinson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 14 Prentiss St. Southville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 28 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1951, to October 28, 1965

I last saw her alive on October 24, 1965 death is said to have occurred on the date stated above, at 11:40a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) metastatic cancer

Due To (b) Papillary cystadenocarcinoma of pancreas — 1 yr

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Operation- Jan. 1965

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signed) Timothy P. Stone, M. D.

(Address) Main St. Southboro, Mass. Date Oct. 28 1965

6 Place of Burial or Cremation: Wildwood Cemetery, Ashland, Mass. (City or Town)

DATE OF BURIAL October 31 1965

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth

ADDRESS 108 Lincoln St. Framingham, Mass.

Received and filed October 29 1965

(Registrar of City or Town where deceased resided) November 1, 1965

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Female	White	Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Albert Hazen Stinson
(Husband's name in full)

12 AGE 82 Years 7 Months 6 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Spinner
(Kind of work done during most working life)

14 Industry or Business: Hat factory

15 Social Security No. 019-10-4375

16 BIRTHPLACE (City) (State or country) Port Elgin New Brunswick, Canada

PARENTS

17 NAME OF FATHER: George Hazen Peacock

18 BIRTHPLACE OF FATHER (City) Big Shemogue (State or country) New Brunswick, Canada

19 MAIDEN NAME OF MOTHER: Laura Belle Taylor

20 BIRTHPLACE OF MOTHER (City) Shemogue (State or country) New Brunswick, Canada

21 Informant (Address): Mrs. Burton B. Derby- daugh 14 Prentiss St. Southville, Mass

A TRUE COPY

ATTEST: Peter P. Corcoran
(Registrar of City or Town where death occurred)

DATE FILED Oct. 29, 1965

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

3 8

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Walter A. Hutt (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Permanent Residence. No. Middle Rd. St. Southboro (City or town and State)

Length of stay: In place of death ..... years ..... months 17 days. In place of residence 72 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 15, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1953, to Nov. 15, 1965

I last saw him alive on Nov. 15, 1965, death is said to have occurred on the date stated above, at 4:40p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Pyelonephritis, chronic	1Yr.+
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? Yes

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date 11/16 1965

6 Rural Cem., Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 18, 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed December 10 1965

Eleanora F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Married

11 If married, widowed, or divorced HUSBAND of Sarah V. Stivers (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 72 Years 8 Months 7 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Rural mail carrier (Kind of work done during most of working life)

14 Industry or Business: U.S. Post Office Dept.

15 Social Security No. 031-26-8071

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER Albert E. Hutt

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Mary Ann Shelnutt

20 BIRTHPLACE OF MOTHER (City) (State or country) Canada

21 Informant Mrs. Walter A. Hutt

(Address) Middle Rd. Southboro, Mass.

A TRUE COPY

ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED Nov. 19, 1965

FORM R-305

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 321

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Taylor (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence No. 72 Newton St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 hour years months days. In place of residence 46 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 13, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic heart disease

5 Accident, suicide, or homicide (specify) no

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Kenneth Greenleaf, M. D.

(Address) Sudbury, Mass Date Dec. 13 65

7 Rural Cemetery, Southboro, Mass. Place of Burial or Cremation. (City or Town)

DATE OF BURIAL December 16 65

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed January 14 66

Edmond F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

12 If married, widowed, or divorced HUSBAND of Alice Coffin (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 77 Years 5 Months 23 Days; If under 24 hours Hours Minutes

14 Usual Occupation: Gardening & Maintenance (Kind of work done during most of working life)

15 Industry or Business: Town Dept.

16 Social Security No. 024-03-3405

17 BIRTHPLACE (City) (State or country) Jewett City, Conn.

PARENTS

18 NAME OF FATHER Joseph Taylor

19 BIRTHPLACE OF FATHER (City) (State or country) England

20 MAIDEN NAME OF MOTHER Maria Roseberry

21 BIRTHPLACE OF MOTHER (City) (State or country) England

22 Informant Mrs. Joseph Taylor (Address) 72 Newton St. Southboro, Mass.

A TRUE COPY ATTEST: Peter P. Cottone (Registrar of City or Town where death occurred)

Agent

DATE FILED Dec. 14, 1965 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... June 25, 1918

DATE OF DISCHARGE ..... March 21, 1919

RANK, RATING ..... CPL.

ORGANIZATION AND OUTFIT ..... 9th Co 151st Depot Brigade Btty F 336th Field Art.

SERVICE NUMBER 2954420

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MINNIE REGINA STOCKWELL
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. 246 (Usual place of abode) St. SOUTHVILLE (If nonresident, give city or town and State)

Length of stay: In place of death 45 years ..... months ..... days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DECEMBER 24 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUGUST, 1960, to DEC 24, 1965

I last saw her alive on DEC 19, 1965, death is said to have occurred on the date stated above, at 3 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) CORONARY THROMBOSIS — 2WK

Due To
(b) CORONARY HEART DISEASE — 5 YR

Due To
(c)

OTHER SIGNIFICANT CONDITIONS: HY PERTENSION — 10 YR

Was autopsy performed? NO

What test confirmed diagnosis? NONE

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify .....

(Signed) Donald E Luke, M. D.
DONALD E. LUKE MD
(PRINT OR TYPE SIGNATURE)

(Address) 161 FRANKLIN ST FRAMINGHAM Date 12-24 1965

6 Rural Cemetery Southboro Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 27, 1965

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 main St Southboro, Mass.

Received and filed December 31, 1965
Edmund T. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James G. Stockwell
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years 10 Months 16 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 013-01-4540½

16 BIRTHPLACE (City) (State or country) Bridgewater N.S. Canada

PARENTS

17 NAME OF FATHER Michael LeGay

18 BIRTHPLACE OF FATHER (City) Bridgewater
(State or country) NS Canada

19 MAIDEN NAME OF MOTHER CNBL

20 BIRTHPLACE OF MOTHER (City) Bridgewater
(State or country) NS. Canada

21 Informant James G. Stockwell
(Address) 246 Parkerville Rd, Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sue a Goodell - Agent
(Signature of Agent of Board of Health or other)

(Official Designation) 12/27/65 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Maria Sartina Bianchi (Bina)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. 14 Pleasant St., St. Southboro (City or town and State)

Length of stay: In place of death.....years.....months 4 days. In place of residence 60 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 28 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept, 1965, to Dec 28, 1965

I last saw her alive on Dec 27, 1965, death is said to have occurred on the date stated above, at 7:20am m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Coronary occlusion — 2-3 dys.

Due To (b) Atherosclerosis — yrs.

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus — 10 yrs.

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) John F. Whitcomb, M. D.

(Address) Framingham Date 12/28/65 19.....

6 Rural Cem. Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 30 19 65

7 NAME OF FUNERAL DIRECTOR Robert P. Norton

ADDRESS Framingham, Mass.

Received and filed January 7 19 66

Edmund T. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Peter Bianchi
(Husband's name in full)

12 AGE 83 Years 1 Months 27 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Homemaker
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 024-22-0595

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Biagio Bina

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Angela DelTochio

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Charles Bianchi
(Address) Curve St., Framingham, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED January 3, 1966 19.....

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

33

Framingham
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. 153 Winter St., St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Gertrude Lewis (Bunce)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Walnut Drive St. Southboro (City or town and State)

Length of stay: In place of death 1½ years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: December (Month) 29 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 18 65, 19..., to Dec 29 65, 19... I last saw her alive on Dec 24 65, 19..., death is said to have occurred on the date stated above, at 5:35pm m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Carcinoma breast, metastatic — INTERVAL BETWEEN ONSET AND DEATH: 16 yrs.
Due To (b) .....
Due To (c) .....
OTHER SIGNIFICANT CONDITIONS .....

Was autopsy performed? no
What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Martin Vogel, M. D.
(Address) Framingham Date 12/29/65, 19...

6 Place of Burial or Cremation: Rural Cem., (City or Town) Southboro, Mass.
DATE OF BURIAL December 31 65, 19...

7 NAME OF FUNERAL DIRECTOR: Donald C. Morris
ADDRESS: Southboro, Mass.

Received and filed January 7 66, 19...
Clarence T. Burbee
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Arastus Lewis (Husband's name in full)

12 AGE: 63 Years 4 Months 12 Days; If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 019-16-7099

16 BIRTHPLACE (City) (State or country): Tunbridge, Vermont

PARENTS

17 NAME OF FATHER: Henry Bunce

18 BIRTHPLACE OF FATHER (City) (State or country): Tunbrdige, Vermont

19 MAIDEN NAME OF MOTHER: Mae Rule

20 BIRTHPLACE OF MOTHER (City) (State or country): England

21 Informant: Dean Lewis
(Address) Walnut Drive, Southboro, Mass.

A TRUE COPY
ATTEST: Richard L. Ward
(Registrar of City or Town where death occurred)
DATE FILED January 3, 1966, 19...

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

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Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. 34

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. 153 Winter St., St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George E. Mathewson (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. Southboro Arms St. Southboro, Mass. (City or town and State)

Length of stay: In place of death 4 years ... months ... days. In place of residence 1 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 29 (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 21, 1961, to Dec 29, 65

I last saw him alive on December 29, 1965, death is said to have occurred on the date stated above, at 10:45pm m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS: Bronchopneumonia — 9 dys.

Was autopsy performed? no

What test confirmed diagnosis? clinical diagnosis

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date 12/29/65 19

6 Pine Grove Cem., Lynn, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 31 65

7 NAME OF FUNERAL DIRECTOR W. C. Parker

ADDRESS Lynn, Mass.

Received and filed January 7 19 66

Clarence F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
male	white	Widowed

11 If married, widowed, or divorced HUSBAND of Elizabeth McKee (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 81 Years 9 Months 2 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Retired Inspector (Kind of work done during most of working life)

14 Industry or Business: General Electric

15 Social Security No. 015-09-8646

16 BIRTHPLACE (City) Fall River, Mass. (State or country)

PARENTS

17 NAME OF FATHER George Mathewson

18 BIRTHPLACE OF FATHER (City) Fall River, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Lucy A. Clough

20 BIRTHPLACE OF MOTHER (City) Fall River, Mass. (State or country)

21 Informant Hazel M. Pickering
Southboro, Mass.
(Address)

A TRUE COPY Arthur G. Ward

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED January 3, 1966 19

ORM R-305

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

(City or Town making this return)

Registered No. .....

No. Framingham Union Hospital St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Michelle Ellis
(If deceased is a married, widowed or divorced woman, give also maiden name.)
{(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. 24 Breakneck Hill Rd., St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 4½ years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 23 (Day) 1966 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Meningococcus meningitis

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury .....19.....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
(How did injury occur?)
Nature of Injury .....
While at work? .....Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Antonio A. Matarese, M. D.

(Address) Framingham Date 1/23/ 19 66

7 St. Tarcisius Framingham
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL January 24 19 66

8 NAME OF FUNERAL DIRECTOR Eugene J. McCarthy
ADDRESS Framingham, Mass.

Received and filed January 28 19 66
Eleanor T. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: female
10 COLOR: white
11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): single

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE.....Years 4½ Months.....Days (4½)
If under 24 hours .....Hours .....Minutes

14 Usual Occupation: .....
(Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

18 NAME OF FATHER Howard Ellis

19 BIRTHPLACE OF FATHER (City) (State or country) Framingham, Mass.

20 MAIDEN NAME OF MOTHER Dolores Leao

21 BIRTHPLACE OF MOTHER (City) (State or country) Framingham, Mass.

22 Informant (Address) Howard B. Ellis 24 Breakneck Hill Rd., Southboro

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)
DATE FILED January 25 19 66

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

PLACE OF DEATH
1 Middlesex (County)
Framingham (City or Town)
No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alexander J. Slack (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Parkervill Rd., St. Southboro (City or town and State)

Length of stay: In place of death 15 mins. years months days. In place of residence 21 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 9 1966 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1949, to Feb 9, 1966

I last saw him alive on Feb 9, 1966, death is said to have occurred on the date stated above, at 12:30pm m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Rheumatic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 62 yrs.

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic heart disease — 2 yrs.

Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 2/9/66 19

6 Pine Grove Cem., Boylston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 12 1966

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed February 21 1966

Eleanor F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
male	white	married

11 If married, widowed or divorced
HUSBAND of Florence Knowlton
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 AGE 78 Years 0 Months 15 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Machinist
(Kind of work done during most of working life)

14 Industry or Business: Machine & Tool

15 Social Security No. 017-10-1545

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Alexander P. Slack

18 BIRTHPLACE OF FATHER (City) Island Pond,
(State or country) Vermont

19 MAIDEN NAME OF MOTHER Mary Gormley

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Canada

21 Informant Mrs. Florence Slack
(Address) 229 Parkerville Rd., Southboro, Mass.

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED February 11 1966

100M-5-64-938000

RM R-305

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Natick (City or Town)

Natick (City or Town making this return)

No. DOA LEONARD MORSE HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edith Edna Taunton (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. ..... Walnut Drive St. Fayville, Mass. (If nonresident, give city or town and State)
(Usual place of abode) DOA

Length of stay: In place of death - years - months ..... days. In place of residence 2 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 27, 1966 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

1. Ruptured Diaphragm
2. Retroperitoneal Hemorrhage
3. Fractured Ribs, Multiple, Left
4. Fractured Right Femur.

5 Accident, suicide, or homicide (specify) ACCIDENT

Date and hour of injury 12:00noon 3/27/ 1966

IF ACCIDENTAL, was injury causally related to the death? YES

Where did Injury occur? Wayland, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Farm (Specify type of place)

Manner of Injury Horse Fell on Deceased (How did injury occur?)

Nature of Injury SEE ABOVE

While at work? NO Was autopsy performed? YES

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) Antonio A. Matarese, M. D.

(Address) Framingham Date 3/27/66 19....

7 Lakeview Cochituate
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL March 30, 1966

8 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons, Inc.

ADDRESS Wayland

Received and filed April 25 1966

Eleanor F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
F.	W.	Single

12 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

13 AGE 48 Years 9 Months 21 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Technical Writer (Kind of work done during most of working life)

15 Industry or Business: Honeywell Company

16 Social Security No. 011-14-8784

17 BIRTHPLACE (City) (State or country) New York City, N.Y.

PARENTS

18 NAME OF FATHER William Henry Taunton

19 BIRTHPLACE OF FATHER (City) (State or country) Somerville, Mass.

20 MAIDEN NAME OF MOTHER Edna Warren Way

21 BIRTHPLACE OF MOTHER (City) (State or country) Medford, Mass.

22 Informant Benjamin W. Taunton
(Address) 17 Sagamore Rd., Marblehead, Mass.

A TRUE COPY
ATTEST: Alfred L. Connell
(Registrar of City or Town where death occurred)

DATE FILED March 29, 1966

FORM R-302

MARGIN RESERVED FOR BINDING

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

4

Framingham
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby boy MILLER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. Southville Rd. St. Southboro (City or town and State)

Length of stay: In place of death 1 years 0 months 0 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 7, 1966
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 6, 66 to April 7, 66

I last saw h..... alive on ..... 19..., death is said to have occurred on the date stated above, at 9:30P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Neonatal atelectasis	1Day
Due To (b) Prematurity	1Day
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) George L. Siegel, M. D.

(Address) Sudbury, Mass. Date 4/8 66

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 9, 66

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed May 6 1966

Eleanor J. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Male	White	Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE ..... Years - Months 1 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Framingham, (State or country) Mass.

PARENTS

17 NAME OF FATHER Martin F. Miller

18 BIRTHPLACE OF FATHER (City) Fond du Lac, (State or country) Wisc.

19 MAIDEN NAME OF MOTHER Mary Doll

20 BIRTHPLACE OF MOTHER (City) Wellesley, (State or country) Mass.

21 Informant Martin F. Miller
(Address) Southville Rd. Southboro, Mass.

A TRUE COPY Michael J. Ward
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED April 13, 1966

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

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100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making thi

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Fram. Union Hospital St. (If death occurred in a hospital or institution give its NAME instead of street and nu

2 FULL NAME Ruth Graham (Emerson) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 193 Parkerville Road St. Southboro, Mass. (City or town and S

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 17, (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan, 19 60, to April 17, 1966

I last saw her alive on April 17, 1966, death is said to have occurred on the date stated above, at 3.45p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Leiomyosarcoma, small bowel — INTERVAL BETWEEN ONSET AND DEATH: 4+yrs

Due To (b) Metastatic liver

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? biopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) Clarence Brown, M. D.

214 N. Main Street

(Address) Natick, Mass. Date 4/18/66 19

6 Place of Burial or Cremation: Rural Cemetery, Southboro, Mass. (City or Town)

DATE OF BURIAL April 21, 1966 19

7 NAME OF FUNERAL DIRECTOR: Donald C. Morris

ADDRESS 40 Main St., Southboro, Mass.

Received and filed May 6 19 66

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write t): Marr

11 If married, widowed, or divorced

HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of William G. Graham (Husband's name in full)

12 AGE 66 Years 1 Months 1 Days — If under 24 ho ..... Hours

13 Usual Occupation: Broker-realtor (Kind of work done during most of workin

14 Industry or Business: real estate

15 Social Security No. 023-22-1256A

16 BIRTHPLACE (City) (State or country): Beverly Mass.

PARENTS

17 NAME OF FATHER: Isaac Emerson

18 BIRTHPLACE OF FATHER (City) (State or country): Beverly Mass.

19 MAIDEN NAME OF MOTHER: Sadie Crompey

20 BIRTHPLACE OF MOTHER (City) (State or country): Beverly Mass.

21 Informant William G. Graham

(Address) 193 Parkerville Rd. Sout

A TRUE COPY

ATTEST: Michael J. Ward (Registrar of City or Town where death occurr

DATE FILED April 20, 1966

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death. →

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a). →

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this ret

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. 3 Pleasant St. (If death occurred in a hospital or institution give its NAME instead of street and numbe

AKA James Louis Noborini

2 FULL NAME Louis James Noborini
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Permanent Residence. No. 3 Pleasant St St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death 41 years ..... months ..... days. In place of residence 41 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: APRIL (Month) 22 (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from NOV. 23, 1965, to APRIL 21, 1966

I last saw him alive on APRIL 21, 1966, death is said to have occurred on the date stated above, at 3:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL BETWEEN ONSET AND DEATH

(a) Acute Coronary occlusion — 1 Hour

Due To (b) Coronary heart Dis — 3 years

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Was autopsy performed? YES

What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased? YES

If so, specify 13 INCREASE 3 yrs AGO AT WORK AS CARPENTER

(Signature) John Paul Ahearn, M. D.

JOHN PAUL AHEARN, M.D
(Print or Type Name)

(Address) MARLBORO, MASS Date APRIL 22, 1966

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 26, 1966

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St Southboro, Mass.

Received and filed April 27 1966

Eleonora F. Burke
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the w MARRIED WIDOWED DIVORCED UNKNOWN
M	White	Marrie

11 If married, widowed, or divorced
HUSBAND of Maria Santella
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 AGE 41 Years 6 Months 15 Days — If under 24 hours ..... Hours ..... Minu

13 Usual Occupation Carpenter
(Kind of work done during most of working life)

14 Industry or Business: Maintenance

15 Social Security No. 024-12-5305

16 BIRTHPLACE (City) Framingham
(State or country) Mass.

PARENTS

17 NAME OF FATHER Louis Noborini

18 BIRTHPLACE OF FATHER (City) Piacenza
(State or country) Italy

19 MAIDEN NAME OF MOTHER Premena Trioli

20 BIRTHPLACE OF MOTHER (City) Southboro
(State or country) Mass.

21 Informant Mrs. Maria Noborini

(Address) 3 Pleasant St, Southboro, M

I HEREBY CERTIFY that a satisfactory standard certificate of was filed with me BEFORE the burial or transit permit was iss

Mrs Sena A. Morcatelli
(Signature of Agent of Board of Health or other)

(Official Designation) 4-25-66 (Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE April 1, 1943

DATE OF DISCHARGE Feb. 13, 1946

RANK, RATING PFC

ORGANIZATION AND OUTFIT Co B. 415th Inf. Reg

SERVICE NUMBER 31 262 108

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or Town making this

Registered No. 131

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Braemoor Nursing Home St. (If death occurred in a hospital or institu give its NAME instead of street and nu

2 FULL NAME Mary (Cummings) Mullins (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) ---

(a) Permanent Residence. No. 250 Parkerville Road St. Southborough, Mass. (City or town and St

Length of stay: In place of death 2 years ... months ... days. In place of residence 15 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 28, 1966 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1952, to April 28, 1966

I last saw her alive on April 26, 1966, death is said to have occurred on the date stated above, at 12:45p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinoma, pelvic (uterus) — INTERVAL BETWEEN ONSET AND DEATH: 18 mos

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS: Pulmonary metastasis — 1 mo

Was autopsy performed? no

What test confirmed diagnosis? physical exam.

5 Was disease or injury in any way related to occupation of deceased? ...

If so, specify no

(Signature) Timothy P. Stone, M. D.

(Address) Southboro, Mass Date Apr. 29 66

Place of Burial or Cremation: St. Mary's Cemetery, Randolph, Mass. (City or Town)

DATE OF BURIAL April 29 66

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed May 2 6 66

Clarence T. Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write th
Female	White	Widow

11 If married, widowed, or divorced

HUSBAND of ... (Give maiden name of wife in full)

(or) WIFE of John D. Mullins (Husband's name in full)

12 AGE 81 Years 11 Months 19 Days — If under 24 hou ... Hours

13 Usual Occupation: Housewife (Kind of work done during most of working

14 Industry or Business: At home

15 Social Security No. 032-01-9175D

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER James Francis Cummings

18 BIRTHPLACE OF FATHER (City) St. Johns N.B. (State or country) Canada

19 MAIDEN NAME OF MOTHER Mary Bond

20 BIRTHPLACE OF MOTHER (City) Boston, Mass. (State or country)

21 Informant Joseph F. Cummings

(Address) 250 Parkerville Rd. Southb Mass.

A TRUE COPY

ATTEST: Peter P. Cottone (Registrar of City or Town where death occurred)

Agent

DATE FILED April 28, 1966

Robert A. Lapsine

100M-5-64-938000

FORM R-301

d for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

not enter
re than one
se for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
, etc. It means
ase, or compli-
which caused

tions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

8

(City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 County (County) .....

Worcester (City or Town)

No. 21 Flagg Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Harry M. Wylde
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Permanent Residence. No. 21 Flagg Road St. Southboro Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 27 years ..... months ..... days. In place of residence 27 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 19 (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JUNE 24, 1965, to MAY 19, 1966

I last saw him alive on MAY 14, 1966, death is said to have occurred on the date stated above, at 3:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) CARCINOMA, PROSTATE — 10 mos

Due To (b) —

Due To (c) —

OTHER SIGNIFICANT CONDITIONS UREMIA

Was autopsy performed? No

What test confirmed diagnosis? X-ray, Laparotomy

5 Was disease or injury in any way related to occupation of deceased? ND

If so, specify —

(Signature) Timothy P. Stone, M. D.

TIMOTHY P. STONE
(Print or Type Name)

(Address) SOUTHBORO Date MAY 21 1966

6 Rural Crematory Worcester, Mass,
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 21, 66

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main Street Southboro Mass

Received and filed May 25, 1966

Eleanor T Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Lillian Richaurd
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 73 Years 6 Months 27 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Chemical Engineer
(Kind of work done during most of working life)

14 Industry or Business Lever Bros

15 Social Security No. 012-10-7687

16 BIRTHPLACE (City) Williamstown
(State or country) Mass

PARENTS

17 NAME OF FATHER Cornelius Wylde

18 BIRTHPLACE OF FATHER (City) CNBL
(State or country) Germany

19 MAIDEN NAME OF MOTHER Mary CNBL

20 BIRTHPLACE OF MOTHER (City) CNBL
(State or country) England

21 Informant Mrs. Lillian Wylde

(Address) 21 Flagg Rd, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) May 19 1966

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....?.....

DATE OF DISCHARGE.....?.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....Chemical Warfare.....

SERVICE NUMBER.....?.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-303

d for burial permit
Board of Health
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this retur

Registered No. .....

No. 119 Northboro Road St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Alice (Dickens) Parmenter
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. 119 Northboro Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 20 (Day) 1966 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes: Hypertensive cardiovasculat disease presumably cerebro-vasculat accident (Found dead in bed)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) S. Alden Gould M.D., M. D.

S. Alden Gould M.D.
(Print or Type Name)

(Address) Grafton Date 5-20 19 66

7 Rural Crematory Worcester, Mass.
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL May 23, 19 66

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed May 25 19 66

A TRUE COPY ATTEST: Eleanora F. Burke (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
F	White	Widowed

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Wallace A. Parmenter
(Husband's name in full)

13 DATE OF BIRTH Jan. 29, 1894

14 AGE 72 Years 3 Months 21 Days | If under 24 hours ..... Hours ..... Mi

15 Usual Occupation: Housewife
(Kind of work done during most of working life

16 Industry or Business: At Home

17 Social Security No. 031-26-7384

18 BIRTHPLACE (City) (State or country) Newbury Mass

PARENTS

19 NAME OF FATHER James Dickens

20 BIRTHPLACE OF FATHER (City) (State or country) Edinburgh Scotland

21 MAIDEN NAME OF MOTHER Jessie Dunbar

22 BIRTHPLACE OF MOTHER (City) (State or country) Edinburgh Scotland

23 Informant (Address) Mrs. Beatrice Johnson 119 Northboro Rd. Southbo

I HEREBY CERTIFY that a satisfactory standard certificate o was filed with me BEFORE the burial or transit permit was is

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

MEDICAL

COPY OF CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

STATE OF NEW HAMPSHIRE

TOWN OR CITY CLERK'S NO. 461

1. NAME OF DECEASED (TYPE OR PRINT) A. (FIRST)	B. (MIDDLE)	C. (LAST)	2. DATE OF DEATH (MONTH) (DAY) (YEAR)
Helen	J.	O'Reilly	5/27/66

3. PLACE OF DEATH A. COUNTY: Hillsborough B. CITY OR TOWN: Manchester C. LENGTH OF STAY (IN THIS PLACE): D. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Elliot Hospital	4. USUAL RESIDENCE (WHERE DECEASED LIVED. IF INSTITUTION: RESIDENCE BEFORE ADMISSION.) A. STATE: N. H. B. COUNTY: Hillsborough C. CITY (GIVE ACTUAL TOWN OF RESIDENCE, NOT MAILING ADDRESS) OR TOWN: Bedford D. STREET ADDRESS (IF RURAL, GIVE LOCATION): 8 Seabee St. E. IS RESIDENCE ON FARM? YES ☐ NO ☒

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ DIVORCED ☐ NEVER MARRIED ☐ WIDOWED ☐	8. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE)		
Female	White		John J. O'Reilly, Sr.		
9. DATE OF BIRTH	10. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	11A. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED)	11B. KIND OF BUSINESS OR INDUSTRY	
6/17/04	61		Housewife		
12. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY)	13. CITIZEN OF WHAT COUNTRY?	14. FATHER'S NAME			
Watertown, Mass.	USA	Frederick J. Wright			
15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES OF SERVICE)	17. SOC. SEC. NO.			
Bridget Agnes Harrigan	No				
18A. INFORMANT	18B. ADDRESS				
John J. O'Reilly, Sr.	8 Seabee St., Bedford, N. H.				

MEDICAL CERTIFICATION

19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (A): Acute posterior myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Week

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST.

DUE TO (B): Arteriosclerotic heart disease — Months

DUE TO (C): Cardiogenic shock

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(A)

20. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

21A. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	21B. DESCRIBE HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II OF ITEM 19.)	
21C. TIME OF INJURY: MONTH DAY YEAR HOUR M.		
21D. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21E. PLACE OF INJURY (E. G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)	21F. CITY, TOWN OR LOCATION COUNTY STATE

22. *I attended the deceased from* 5/17/66 *to* 5/27/66 *and last saw* her/~~him~~ *alive on* 5/27/66
Death occured at 6:15P *m on the date stated above; and to the best of my knowledge, from the causes stated.*

23A. SIGNATURE (DEGREE OR TITLE)	23B. ADDRESS	23C. DATE SIGNED
Paul Harkinson, M. D.	Manchester, N. H.	5/27/66

24A. BURIAL ☒ CREMATION ☐ ENTOMBMENT ☐ REMOVAL ☐	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE)
	5/31/66	Rural Cem.	Southboro, Mass.

IF ENTOMBED 24E. PLACE OF BURIAL (NAME OF CEMETERY)	LOCATION (CITY, TOWN, COUNTY) (STATE)	DATE

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	COUNTERSIGNED-AGENT (CITY BD. OF HEALTH)	DATE
M. J. Connor, Manchester, N.H.	James J. Powers, M.D.	6/2/66

DATE REC'D BY TOWN OR CITY CLERK	CLERK'S OWN SIGNATURE	CLERK OF
6/2/66	M. J. Quinn	Manchester, N. H.

A true copy, Attest: M. J. Quinn *Clerk of* Manchester *Dated* 6/2/ 66

VS 17 Rec'd June 3, 1966

43940-x 7-64—25M

Theresa F. Burke

COPY CERTIFICATE OF DEATH
STATE OF VERMONT

DH-VS-5X-22M-62 Certificate No.....

Please type (except signature) or write plainly with unfading ink. This is a Permanent Record. Do not use a ball point pen.

1. FULL NAME OF DECEASED (First) (Middle) (Last): John A. Muiry
2. DATE OF DEATH (Month) (Day) (Year): May 29, 1966

3. PLACE OF DEATH
a. COUNTY: Orleans
b. CITY OR TOWN (If rural, please state): Orleans
c. LENGTH OF STAY (In this place): 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Roderick Gallup Residence

4. USUAL RESIDENCE (If institution—residence before admission)
a. STATE: Massachusetts
b. COUNTY:
c. CITY OR TOWN (If rural, please state): Southboro
d. STREET ADDRESS (If rural, give R. F. D. number): 20 Atwood Road

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS (Check one)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year Months Days	If under 24 hrs. Hours Mins.
Male	White	S☐ M☒ W☐ D☐	1-15-1899	67		

10a. USUAL OCCUPATION (Kind of work done most of working life)	10b. BUSINESS OR INDUSTRY	11. BIRTHPLACE	12. CITIZEN OF WHAT COUNTRY?
Retired Salesman	Real Estate	Barre, Vermont	U. S. A.

13. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
John Muiry	Julia Mitchell

14. FATHER'S BIRTHPLACE (Town) (State or Country)	16. MOTHER'S BIRTHPLACE (Town) (State or Country)	17. NAME OF HUSBAND OR WIFE
Aberdeen, Scotland	Aberdeen, Scotland	Olive Perkins

18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, XXXXXX) (Give war & dates of service)	19. SOCIAL SECURITY NO.	20. INFORMANT'S NAME (Person giving this information)
XX	013-05-9408	Mrs. Olive Muiry

21.

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complications which caused death.	Medical Certification	DURATION
	(a) Coronary Thrombosis	sudden
	DUE TO (b) Coronary Sclerosis	years
ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Arteriosclerotic Heart Disease	years
II. OTHER SIGNIFICANT CONDITIONS (Contributing to the death but not related to disease or condition causing it)		

Every item must be carefully filled in. Physicians should enter only one cause per line for (a), (b), and (c). Exact statement of occupation is very important.

22. DATE OF OPERATION	22a. MAJOR FINDINGS OF OPERATION	23. AUTOPSY
		Yes ☐ No ☒

24a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	24b. PLACE OF INJURY (In home, farm, factory, street, etc.)	24c. CITY OR TOWN COUNTY STATE

24d. TIME OF INJURY (Month, day, year) (hour) .....m	24e. INJURY OCCURRED While at work ☐ Not at work ☐	24f. HOW DID INJURY OCCUR?

[conducted a post-mortem examination on the body of the decedent]

25. I hereby certify that I [attended the deceased from Unattended death 19....., to .....19....., that I last saw deceased alive] on.....19..... and that death occurred at 4:30A m, from the cause and on the date stated above.

26a. SIGNATURE (Degree or Title)	26b. ADDRESS	26c. DATE SIGNED
T. F. Gage Medical Examiner	Orleans, Vt.	5-29-66

27a. BURIAL, CREMATION, REMOVAL (Specify)	27b. DATE	27c. NAME OF CEMETERY OR CREMATORY	27d. LOCATION (Town or County) (State)
Burial	6-2-66	Mt. Wollaston Cemetery	Quincy, Mass.

28. DATE REC'D BY TOWN OR CITY CLERK	29. CLERK'S SIGNATURE (Clerk's signature)	30. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
May 29, 1966	Phyllis H. Drake	Converse Funeral Service, Inc. Newport, Vermont, By Mack Converse B.

Attest: Phyllis H. Drake Date: June 10, 1966

Rec'd June 13, 1966 Eleanor T. Burke

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Cushing Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ada Battye (Pearson)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Deerfoot Rd., St. Southboro, Mass. (City or town and State)

Length of stay: In place of death 10 years 9 months ..... days. In place of residence 21 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 30 (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 6, 1965, to May 30 1966

I last saw her alive on May 30 1966, death is said to have occurred on the date stated above, at 4.40pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Bacteremic shock — 1 dy.

Due To (b) Bronchopneuminia and cellulitis — 7 dys.

Due To (c) Submandibular region

OTHER SIGNIFICANT CONDITIONS: Diabetes mellitus, cerebral thrombosis

Was autopsy performed? no

What test confirmed diagnosis? clinical findings

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Dhia Allahverdi, M. D.

(Address) Cushing Hosp Date 5/30/66

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 1 66

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed June 15 1966

Edward J. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Percy Battye
(Husband's name in full)

12 AGE 73 Years 2 Months 24 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) England

PARENTS

17 NAME OF FATHER Henry Pearson

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Elizabeth Bottoms

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Cushing Hospital Records
Framingham, Mass.
(Address)

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED June 2, 1966

RM R-302

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-9-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

NEWTON (City or Town making this return)

Registered No. 326-66

1 PLACE OF DEATH: MIDDLESEX (County); NEWTON (City or Town)

No. Newton—Wellesley Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas A McDonald, Sr.
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 2 Richards Road St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death - years - months 7 days. In place of residence - years 9 months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: May (Month) 31 (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 22 im, 1966, to May 31, 1966

I last saw h alive on May 30, 1966, death is said to have occurred on the date stated above, at 8:50 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Carcinoma of Lung	6 Mo.
Due To (b)	Adrenal Metastases	2 Wk.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? Yes

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify No

(Signature) Joseph P. Lynch, M. D.

2000 Washington St.

(Address) Newton Date May 31, 1966

6 Place of Burial or ~~Cremation~~: St. Patrick's Cemetery Natick (City or Town)

DATE OF BURIAL June 3, 1966

7 NAME OF FUNERAL DIRECTOR: John Everett & Sons
Mrs. P. Everett

ADDRESS: Natick, Mass.

Received and filed July 18, 1966

Eleanora F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Married

11 If married, widowed, or divorced
HUSBAND of Pauline A. Murphy
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 55 Years - Months - Days | If under 24 hours Hours Minutes

13 Usual Occupation: Marketing Research Ex.
(Kind of work done during most of working life)

14 Industry or Business: Pharmaceutical Co.

15 Social Security No. 048 - 01 - 3578

16 BIRTHPLACE (City) (State or country): Clinton, Mass.

PARENTS

17 NAME OF FATHER: Thomas F. McDonald

18 BIRTHPLACE OF FATHER (City) (State or country): C.N.B.L. Ireland

19 MAIDEN NAME OF MOTHER: Mary Kitteridge

20 BIRTHPLACE OF MOTHER (City) (State or country): C.N.B.L. Ireland

21 Informant: Pauline McDonald

(Address) 2 Richards Rd., Southboro, Mass.

A TRUE COPY

ATTEST: Joseph H. Kurlan
(Registrar of City or Town where death occurred)

DATE FILED June 6, 1966

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-61-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 196

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Braemoor Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Marlborough (City or Town making this return)

2 FULL NAME Ernest Mayo Jacobs (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. Turnpike Road St. (Fayville) Southboro, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 30, 1966 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 10, 1966, to June 29, 1966

I last saw h alive on June 29 in 66, death is said to have occurred on the date stated above, at 5:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral thrombosis — 20 hrs

Due To (b) cerebral arteriosclerosis — 5 yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) John Paul Ahearn, M. D.

(Address) Marlboro, Mass Date June 30 1966

6 Place of Burial or Cremation Rose Cemetery, Brooks, Maine (City or Town)

DATE OF BURIAL July 2 1966

7 NAME OF FUNERAL DIRECTOR McNamara Funeral Home

ADDRESS 460 Washington St., Brighton, Mass

Received and filed July 8 1966

Edward J. Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Widowed

11 If married, widowed, or divorced HUSBAND of Clara Helen Miller (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 84 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Theatrical Agent (Kind of work done during most of working life)

14 Industry or Business: Public Relations

15 Social Security No. 023-03-6478

16 BIRTHPLACE (City) (State or country) Brooks, Maine

PARENTS

17 NAME OF FATHER Whalen Frank Jacobs

18 BIRTHPLACE OF FATHER (City) (State or country) Old Town, Maine

19 MAIDEN NAME OF MOTHER Laura Edith Ham

20 BIRTHPLACE OF MOTHER (City) (State or country) Brooks, Maine

21 Informant E. M. Jacobs

(Address) Turnpike Rd. Fayville, Mass

A TRUE COPY Rita A. Lapine

ATTEST: Peter P. Cottone (Registrar of City or Town where death occurred)

DATE FILED June 30, 1966

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bertha Laura Call (Shaw)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. 12 Winchester St., St. Southboro (City or town and State)

Length of stay: In place of death 6 years ..... months ..... days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) July (Day) 9 (Year) 1966

4 I HEREBY CERTIFY, That I attended deceased from July 2, 1966, to July 9, 1966
I last saw h alive on July 8, 1966, death is said to have occurred on the date stated above, at ..... m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cardiacfarrest

Due To (b) Arteriosclerotic heart disease — Yrs.

Due To (c) Fatty degeneration of heart — Yrs.

OTHER SIGNIFICANT CONDITIONS: Pulmonary emboli

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) Robert N. Levin, M. D.

(Address) Framingham Date 7/11/66 19

6 Place of Burial or Cremation Wyoming Cem. Melrose (City or Town) Mass

DATE OF BURIAL July 12 66

7 NAME OF FUNERAL DIRECTOR Norman P. Robinson

ADDRESS Melrose, Mass.

Received and filed July 27, 19 66

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	white	Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of George A Call
(Husband's name in full)

12 AGE Years 91 Months 10 Days 28 — If under 24 hours Hours ..... Minutes

13 Usual Occupation: at home
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER William B. Shaw

18 BIRTHPLACE OF FATHER (City) (State or country) Malden, Mass.

19 MAIDEN NAME OF MOTHER Lillie Louise Otto

20 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

21 Informant Mrs. Laura G. Gordon
(Address) 51 Curve St., Wellesley, Mass.

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED July 11, 1966 19

ORM R-301

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 15

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. 43 Boston Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anthony Pessolano
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 43 Boston Rd St. Southboro Mass
(Usual place of abode) (City or town and State)

Length of stay: In place of death 10 years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 29 (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 7/29, 1966, to 7/29, 1966

I last saw ~~him~~ alive on 7/29, 1966 death is said to have occurred on the date stated above, at 5:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) hepatic Coma	2 days
Due To (b) Carcinoma Tosis	6 mos
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Carcinoma of large Bowel	4 yrs

Was autopsy performed? No

What test confirmed diagnosis? hospitalized 6 mos Ago

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Marilyn Meserve, M. D.
Marilyn Meserve MD
(Print or Type Name)

(Address) Southboro Date 8/1 1966

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 1 1966

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed August 3, 1966

Eleanor F. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
M	White	Widowed

11 If married, widowed, or divorced
HUSBAND of Vita Martucci
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 76 Years 11 Months 27 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Shoes
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 083-10-7247

16 BIRTHPLACE (City) Ardina
(State or country) Italy

PARENTS

17 NAME OF FATHER Vincent Pessolano

18 BIRTHPLACE OF FATHER (City) Ardina
(State or country) Italy

19 MAIDEN NAME OF MOTHER Louise Pollandino

20 BIRTHPLACE OF MOTHER (City) Ardina
(State or country) Italy

21 Informant Edward A. Pessolano

(Address) 43 Boston Rd Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sylvia A Tocchetti
(Signature of Agent of Board of Health or other)

(Official Designation)

8-1-66
(Date of Issue of Permit)

Medical examiner declines jurisdiction

A TRUE COPY ATTEST:

17

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-5-61-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Barnstable
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Barnstable (County); Barnstable (City or Town)

No. (Hyannis) Cape Cod Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles A. Riddle
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) W.W. II

(a) Permanent Residence. No. Gilmore Rd. St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 24 (Day) 1966 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death on way to Hosp. in ambulance. Ant. descending coronary occlusion

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury (Also miliary TBC with spread to liver - spleen)

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) E. Robert Harned, M. D.

(Address) Chatham, Mass. Date 8-25-66 19....

7 Rural Cemetery - Southboro
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Aug. 27, 66

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St., Southboro, Mass.

Received and filed September 7, 1966

Clerence F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Male	White	Married

12 If married, widowed, or divorced
HUSBAND of Louise Pariselli
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE 41 Years 11 Months 1 Days | If under 24 hours: .....Hours .....Minutes

14 Usual Occupation: Metallurgist
(Kind of work done during most of working life)

15 Industry or Business: Watertown Arsenal U.S.A.

16 Social Security No. 019-12-6526

17 BIRTHPLACE (City) (State or country) (Brighton) Boston, Mass.

PARENTS

18 NAME OF FATHER Harry Riddle

19 BIRTHPLACE OF FATHER (City) London, (State or country) England

20 MAIDEN NAME OF MOTHER Elizabeth Davis

21 BIRTHPLACE OF MOTHER (City) London, (State or country) England

22 Informant Mrs. Louise Riddle
(Address) 6 Gilmore Rd.
Southboro, Mass.

A TRUE COPY
ATTEST: Harold W. Sears
(Registrar of City or Town where death occurred)

DATE FILED Aug. 26, 66

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... 12-24-41 .....

DATE OF DISCHARGE ..... 10-5-45 .....

RANK, RATING ..... T-M-1C .....

ORGANIZATION AND OUTFIT ..... U.S. Navy .....

SERVICE NUMBER ..... 202-10-79 .....

.....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Price (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. Pearl St. Southboro, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1966 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 8/23, 1966, to 8/25, 1966

I last saw him alive on August 25, 1966, death is said to have occurred on the date stated above, at 9:45A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: Days?

Due To (b) Perforated intra abdominal viscus — ?

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS Congestive heart failure — Yrs.?

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signature) Robert M. Levin, M. D.

(Address) Framingham Date 8/25 1966

6 Rural Cemetery, Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 28 1966

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed September 3 1966

Clarence F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Male	white	single

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 64 Years 5 Months 3 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Stationary engineer (Kind of work done during most of working life)

14 Industry or Business: Cordaville Mills

15 Social Security No. 020-16-1009

16 BIRTHPLACE (City) Boston, Mass. (State or country)

PARENTS

17 NAME OF FATHER Charles Price

18 BIRTHPLACE OF FATHER (City) Boston, (State or country) Mass.

19 MAIDEN NAME OF MOTHER CNBL

20 BIRTHPLACE OF MOTHER (City) CNBL (State or country)

21 Informant Frank Perini

(Address) Southville Rd. Southboro, Mass.

A TRUE COPY

ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED August 29 1966

100M-5-64-938000

FORM R-301

ed for burial permit
Board of Health
or its Agent.

NSTRUCTIONS
FOR
CAL CERTIFICATE

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condition given

-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 18

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. 6 Cherry Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Louise Ann (Bossi) Berry
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 6 Cherry Street St. Southboro Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 16 years ..... months ..... days. In place of residence 16 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 20 (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JULY 1, 1966, to Sept. 20, 1966

I last saw her alive on Sept 20, 1966, death is said to have occurred on the date stated above, at 11:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Glioma of Thalamus — INTERVAL BETWEEN ONSET AND DEATH: 1yr?

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No Biopsy

What test confirmed diagnosis? Scanning + Surgery

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Peter P. Cottone, M. D.

Peter Paul Cottone
(Print or Type Name)

(Address) Marlboro, Mass. Date Sept. 22 1966

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 24 1966

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 10 Main St. Southboro, Mass.

Received and filed September 27, 1966

Eleanor F. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Paul J. Berry
(Husband's name in full)

12 AGE 39 Years 0 Months 28 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at Home

15 Social Security No. 024-20-3325

16 BIRTHPLACE (City) Framingham
(State or country) Mass

PARENTS

17 NAME OF FATHER: Stephen Bossi

18 BIRTHPLACE OF FATHER (City) Milan
(State or country) Italy

19 MAIDEN NAME OF MOTHER: America Mazzuchelli

20 BIRTHPLACE OF MOTHER (City) Milan
(State or country) Italy

21 Informant: Paul J. Berry

(Address) 6 Cherry St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Sina A. Torcoletti
(Signature of Agent of Board of Health or other)

Agent
(Official Designation)

9-22-66
(Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

) be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 136611

PLACE OF DEATH

1 OUT-OF-TOWN
Suffolk (County)
Boston (City or Town)
No. THE BOSTON FLOATING HOSPITAL, 20 Ash St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Leonard Pierce (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NONE

(a) Permanent Residence. No. Richards Road St. Southboro, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 17 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 3 1966 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1966, to Oct. 3, 1966

I last saw him alive on Oct. 3 1966 death is said to have occurred on the date stated above, at 10:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Multiple congenital anamolies — INTERVAL BETWEEN ONSET AND DEATH

Due To (b) possible intrauterine infection

Due To (c)

OTHER SIGNIFICANT CONDITIONS Single ventricle, cirrhosis

Was autopsy performed? yes.

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Norman L Fienman M. D.

NORMAN L FIENMAN (Print or Type Name)

(Address) Boston Floating Date 10/4 1966

6 RURAL CEMETERY SOUTHBORO MASS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT 6 1966

7 NAME OF FUNERAL DIRECTOR DONALD C. MORRIS

ADDRESS 40 MAIN ST SOUTHBORO MASS

Received and filed OCT 12 1966 19

Rec'd Nov. 4 1966

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: WHITE

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years 3 Months Days 5 Days — If under 24 hours Hours Minutes

13 Usual Occupation (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) FRAMINGHAM MASS

PARENTS

17 NAME OF FATHER WILLIAM H PIERCE

18 BIRTHPLACE OF FATHER (City) SOUTH KINGSTON (State or country) R. I.

19 MAIDEN NAME OF MOTHER JEAN WALTERMIRE

20 BIRTHPLACE OF MOTHER (City) NEW HAVEN (State or country) CONN

21 Informant MRS. JEAN PIERCE

(Address) 204 PARKERVILLE RD SOUTHBORO MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

OCT 5 1966 (Date of Issue of Permit)

154.5
128

100M-3-65-939763

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

19

COPY OF CERTIFICATE OF DEATH

(City or Town making this return) Marlborough

Registered No. 278

PLACE OF DEATH

1 (County) Middlesex

(City or Town) Marlborough

No. ... St. Braemoor Rest Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth (Candy) Wheeler (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. ... St. Central Fayville, Mass. (City or Town and State)

Length of stay: In place of death 5 years ... months ... days. In place of residence 28 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) October (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 19 56, to October 8, 19 66, that I last saw h alive on October 1, 19 66, death is said to have occurred on the date stated above, at 2:40 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

Due To (b) atherosclerosis

Due To (c) ...

OTHER SIGNIFICANT CONDITIONS Rheumatic heart dis.

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? ... If so, specify no

(Signature) Timothy P. Stone, M. D.

(Address) Southboro, Mass Date Oct. 9 19 66

6 Place of Burial, Cremation or Removal Rural Cemetery, Southboro, Mass. (City or Town)

DATE OF BURIAL October 9 19 66

7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell

ADDRESS 133 West Main St. Marlboro, Mass.

Received and filed October 10, 66

Eleanor T. Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of ... (Give maiden name of wife in full)
(or) WIFE of Alfred Ernest Wheeler (Husband's name in full)

12 AGE 99 Years 7 Months 20 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: housewife (Kind of work done during most of working life)

14 Industry or Business: ---

15 Social Security No. ---

16 BIRTHPLACE (City) ----- (State or country) Southampton, England

PARENTS

17 NAME OF FATHER Alfred Candy

18 BIRTHPLACE OF FATHER (City) ... (State or country) London, England

19 MAIDEN NAME OF MOTHER Rebecca Hatton

20 BIRTHPLACE OF MOTHER (City) ... (State or country) London, England

21 Informant Mr. Frank D. Wheeler - son

(Address) Westboro, Mass.

A TRUE COPY
ATTEST: Peter P. Cotrone (Registrar of City or Town where death occurred)

DATE FILED Oct. 8, 1966 Agent

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 10383

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ALVIN R. ANDERSON (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW2

(a) Permanent Residence. No. 106 Russell Road xx Framingham, Mass. (City or town and State)

Length of stay: In place of death.....years.....months 11 days. In place of residen life years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 30 (Day) 1966 (Year)

4 I HEREBY CERTIFY, That VA attended deceased from October 19 1966, to October 30, 1966, death is said to have occurred on the date stated above, at 7:40 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory failure. — Due To

(b) Bilateral pulmonary tuberculosis. — Due To

(c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: days-weeks; years

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased No.

If so, specify

(Signature) Ray W. Pensinger, M. D.

RAY W. PENSINGER (Print or Type Name)

(Address) VAH Boston, Mass. Date Oct. 30 1966

6 Rural Cemetery Southboro (Place of Burial or Cremation; City or Town)

DATE OF BURIAL November 2 1966

7 NAME OF FUNERAL DIRECTOR Boyle Bros., Funeral Home

ADDRESS 173 Union Ave., Framingham, Mass.

Received and filed NOV 1 1966 (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Married

11 If married, widowed, or divorced HUSBAND of Virginia Restelli (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 51 Years 3 Months 19 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation Accountant (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 012 14 6381

16 BIRTHPLACE (City) Wellesley (State or country) Massachusetts

PARENTS

17 NAME OF FATHER Oscar Anderson

18 BIRTHPLACE OF FATHER (City) Wellesley (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Mary Downs

20 BIRTHPLACE OF MOTHER (City) Nova Scotia (State or country) Canada

21 Informant VA Hospital Records, 150 So. Huntington Ave., Boston, Mass. (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (Official Designation)

OCT 31 1966 (Date of Issue of Permit)

B

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Rec'd Dec. 2, 1966

J. Burke

100M-9-65-941327

The Commonwealth of Massachusetts

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death. →

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }

Conditions contributing to death but not related to the terminal disease condition given in (a). →

4221
81
170

Funeral Directors Please use only BLACK Ink.

100M-9-65-941327

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Boston
(City or Town making this return)

Registered No. 10714

PLACE OF DEATH

1 SUFFOLK (County) OUT OF - TOWN
BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MR. HARRY LOWE (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Permanent Residence. No. 50 EVERGREEN AVE Somerville, MASS. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 5 1966 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1966, to Nov. 5, 1966, I last saw him alive on Nov. 5, 1966, death is said to have occurred on the date stated above, at 10:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial Infarction — Hours

Due To (b) Arteriosclerotic Cardiovascular Disease — Years

Due To (c)

OTHER SIGNIFICANT CONDITIONS Prostatic Carcinoma — Years

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) Chas. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 11-5 1966

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 8, 1966

7 NAME OF FUNERAL DIRECTOR Elwood G. Bryant

ADDRESS 181 Broadway, Somerville, Mass.

Received and filed NOV 9 1966 19.....

A TRUE COPY ATTEST: Robert J. Vance (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Male	White	Single

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 77 Years 1 Months 16 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation Unemployed (Kind of work done during most of working life)

14 Industry or Business: 100% Disability

15 Social Security No. None

16 BIRTHPLACE (City) Westboro, (State or country) Mass.

PARENTS

17 NAME OF FATHER Theodore L. Lowe

18 BIRTHPLACE OF FATHER (City) Southboro, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Mae Ann Davis

20 BIRTHPLACE OF MOTHER (City) Southboro, (State or country) Mass.

21 Informant Mr. E. J. Steeves

(Address) 87 Thurston St., Somerville, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) Dec. 1966

Rec'd December 19, 1966

FORM R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

21

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

No. 43 Main St., Southboro, Mass. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Charles Eric Wiseman (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 43 Main St. St. Southborro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 15 years ..... months ..... days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec (Month) 4 (Day) 1966 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Natural causes: Heart disease
Presumably Myocardial Infarction
(Found dead on street)

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) S. Alden Gould M.D.
S. ALDEN GOULD M.D.
(Print or Type Name)
(Address) Grafton Date Dec 4 1966

7 Rural Crematory Worcester Mass
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL Dec. 7, 1966

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS 40 Main St. Southboro, Mass.

Received and filed Dec. 7 1966
Eleanor F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
M	White	YES ☐ NO ☒	☐ ☒ ☐ ☐ ☐

12a If married, widowed, or divorced
HUSBAND of Marie Antoinette LeFent
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 DATE OF BIRTH March 21, 1908

14 AGE 58 Years 8 Months 14 Days | If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Teacher
(Kind of work done during most of working life)

16 Industry or Business: St. Marks School

17 Social Security No. 162-28-3714

18 BIRTHPLACE (City) Gravesend
(State or country) England

PARENTS

19 NAME OF FATHER David William Wisemen

20 BIRTHPLACE OF FATHER (City) CNBL
(State or country) England

21 MAIDEN NAME OF MOTHER Kate Probyn

22 BIRTHPLACE OF MOTHER (City) CNBL
(State or country) England

23 Informant Mrs. William Wiseman
(Address) 43 Main St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Anna Sima A. Tocarletti
(Signature of Agent of Board of Health or other)
(Official Designation) 12/5/66 (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE Jan. 29,1943 Canadian Air Force

DATE OF DISCHARGE April 26,1946

RANK, RATING Capt. Air Force

ORGANIZATION AND OUTFIT 126 Air Wing

SERVICE NUMBER C-23174

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

22

(City or Town making this return)

Registered No.

1 PLACE OF DEATH: Worcester (County); Southville - Southboro (City or Town); No. 223 Parkerville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Belle L. (Perry) Norcross (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 223 Parkerville Road St. Southville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 30 years ..... months ..... days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: December (Month) 7, (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1960, to Dec 7, 1966

I last saw her alive on Dec 5, 1966, death is said to have occurred on the date stated above, at 6:00 A.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Rheumatic Heart Disease	yrs.
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease	6 yrs +

Major findings: Of operations —

Date of operation — Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Timothy P. Sullivan, M. D.

(Address) SOUTHBORO, MASS Date Dec 8 1966

6 Southboro Cemetery, Southboro, Mass (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL December 9, 1966

7 NAME OF FUNERAL DIRECTOR Henry A. Chesmore

ADDRESS 854 Washington St., Hollisto

Received and filed December 9 1966

Eleanora F. Burke (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
female	white	married

10a If married, widowed, or divorced HUSBAND of — (Give maiden name of wife in full)

(or) WIFE of Arthur Z. Norcross (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 7 Months 25 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: —

15 Social Security No.

16 BIRTHPLACE (City or Country) Ringe (State or country) New Hampshire

PARENTS

17 NAME OF FATHER Jason Perry

18 BIRTHPLACE OF FATHER (City) — (State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Elsie A. Page

20 BIRTHPLACE OF MOTHER (City) Fitchburg (State or country) Massachusetts

21 Informant Arthur Z. Norcross (Address) 223 Parkerville Rd., Southvill e

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Selma a Ingaleth Agent (Signature of Agent of Board of Health or other)

(Official Designation) 12-8-66 (Date of Issue of Permit)

50M-7-54-912822

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Truth A. Ober (Chamberlain) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. 18 Main St., St. Southboro, Mass. (City or town and State)

Length of stay: In place of death.....years.....months 1 days. In place of residence 80 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 9 (Month) (Day) 1966 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 5, 19 .., to December 9, 1966

I last saw h alive on December 9 19 66 death is said to have occurred on the date stated above, at 6:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Coronary thrombosis	2½ hrs.
Due To (b)	Arteriosclerotic heart disease	5 yrs.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Diabetes Mellitus	12 yrs.

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 12/11/ 66

6 Rural Cem. Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 12 66

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed December 30 19 66

Clemence F. Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Raymond A. Ober
(Husband's name in full)

12 AGE 80 Years 7 Months 00 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Seamstress (Kind of work done during most of working life)

14 Industry or Business: Fay School

15 Social Security No. 022-05-2277A

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER Joseph A. Chamberlain

18 BIRTHPLACE OF FATHER (City) (State or country) Southboro, Mass.

19 MAIDEN NAME OF MOTHER Hannah Gledhill

20 BIRTHPLACE OF MOTHER (City) (State or country) Southboro, Mass.

21 Informant Mrs. Ruth Lincoln Elliott, Maine

(Address)

A TRUE COPY Michael J. Ward

ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED December 14, 1966

ORM R-303

filed for burial permit
th Board of Health
or its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

2 3

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH

1 Worcester (County)
Southboro (City or Town)

(City or Town making this return)

Registered No. .....

No. Water - west side of White Bagley Rd. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Blanche E (Crocker) Chisholm
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. 4 Viewhill Rd. s Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 10 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 20, 1966
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxiation by Submersion
(Found under ice in reservoir, Suicide)

5 Accident, suicide, or homicide (specify) Suicide

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) ..... , M. D.

(Print or Type Name)

(Address) 540 Belmont St. Worc. Date 12-20-1966

7 Immaculate Conception Cem. Marlboro
Place of Burial or ~~Cremation~~ (City or Town)

DATE OF BURIAL Dec. 23, 1966

8 NAME OF FUNERAL DIRECTOR Arthur P. Reeve

ADDRESS Marlboro Mass.

Received and filed December 28 19 66

Clerk

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	White	Married

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Archibald Chisholm
(Husband's name in full)

13 AGE 76 Years .....Months .....Days. If under 24 hours .....Hours .....Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: At Home

16 Social Security No. 027-38-2075

17 BIRTHPLACE (City) Marlboro
(State or country) Mass

PARENTS

18 NAME OF FATHER George E. Crocker

19 BIRTHPLACE OF FATHER (City) Barnstable
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Annie Moynihan

21 BIRTHPLACE OF MOTHER (City) Stow
(State or country) Mass

22 Informant Miss Barbara Chisholm
(Address) 4 Viewhill Rd., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Susan Lorenette
(Signature of Agent of Board of Health or other)

(Official Designation) 12-22-66 (Date of Issue of Permit)

MEDICAL

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Middlesex (County)

Framingham (City or Town)

No. Winter Gables Nursing Home St. 340 Winter St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Myrtle Blanchard (Mace)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. Woodland Rd. St. Southboro (City or town and State)

Length of stay: In place of death 6 years ..... months ..... days. In place of residence 18 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 11, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 7, 1966 to Jan. 11, 1967

I last saw her alive on Jan. 10, 1967, death is said to have occurred on the date stated above, at 10:50A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Carcinoid, malignant, rectum	28Mons
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date 1/11 19 67

6 MainSt. Cem., Hudson, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 14, 19 67

7 NAME OF FUNERAL DIRECTOR John A. Kennedy

ADDRESS Hudson, Mass.

Received and filed January 20 19 67

Eleanor F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Female	White	Married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Homer W. Blanchard
(Husband's name in full)

12 AGE 78 Years 2 Months 4 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 026-30-8069

16 BIRTHPLACE (City) (State or country) Hudson, Mass.

PARENTS

17 NAME OF FATHER Francis M. Mace

18 BIRTHPLACE OF FATHER (City) Boston, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Jessie M. Hapgood

20 BIRTHPLACE OF MOTHER (City) Hudson, (State or country) Mass.

21 Informant Stanley MacNeill

(Address) 45 River St. Hudson, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED Jan. 13, 1967

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

4

Framingham (City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Middl (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Clasby (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. 202 Parkerville Rd., St. Southboro (City or town and State)

Length of stay: In place of death.....years.....months. ½ days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 16, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 16 '67, 19.., to January 16 '67, 19.., I last saw h alive on Jan 16 '67, 19.., death is said to have occurred on the date stated above, at 2.0.. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congenital anomaly — INTERVAL BETWEEN ONSET AND DEATH: Mins.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? .....
What test confirmed diagnosis? yes

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify no

(Signature) R. L. Jones, M. D.

(Address) Framingham Date Jan 16 19 67

6 Rural Cem. Southboro Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 18 67

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed February 20, 19 67

Eleanora F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
female	white	single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE .....Years.....Months.....Days | If under 24 hours ½ Hours.....Minutes

13 Usual Occupation: .....
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Framingham, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Chester F. Clasby

18 BIRTHPLACE OF FATHER (City) Waltham, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Helen Kofos

20 BIRTHPLACE OF MOTHER (City) Newport, Vermont
(State or country)

21 Informant Chester F. Clasby
(Address) 202 Parkerville Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)
DATE FILED January 18 19 67

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

3

1 PLACE OF DEATH: (County) Middlesex (City or Town making this return) Framingham
(City or Town) Framingham Registered No. .....
No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Luther C. Hooper (Was deceased a U. S. War Veteran, if so specify WAR) .....
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 18 Main St., St. Southboro, Ward (Or, town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) January (Day) 16, (Year) 1967

4 I HEREBY CERTIFY, That I attended deceased from November 58, 19.., to January 16 67, 19.., I last saw h.. alive on January 16 67, 19.., death is said to have occurred on the date stated above, at .....m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary occlusion	1 dy.
Due To (b) Coronary atherosclerosis	10 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Diabetes mellitus	10 yrs.

Was autopsy performed? yes
What test confirmed diagnosis? clinical & autopsy

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify ..... no

(Signature) Robert E. Johnson, M. D.

(Address) Framingham Date Jan 18 19 67

6 Place of Burial or Cremation Walnut Grove Cem., (City or Town) N. Brookfield, Mass.

DATE OF BURIAL January 19 1967

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed February 20 19 67

Maureen F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
male	white	married

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full) Madelina Kawalek
(or) WIFE of ..... (Husband's name in full)

12 AGE 67 Years 2 Months 19 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation Foreman (Kind of work done during most of working life)

14 Industry or Business Metropolitian Dist. Comm.

15 Social Security No. 025-01-3440

16 BIRTHPLACE (City) (State or country) Calais, Maine

PARENTS

17 NAME OF FATHER Aaron Hooper

18 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass.

19 MAIDEN NAME OF MOTHER Emily Cochran

20 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

21 Informant Mrs. Luther C. Hooper

(Address) 18 Main St., Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED January 19,1967 19

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 23

1 PLACE OF DEATH: Middlesex (County) — Marlborough (City or Town) — Marlborough (City or Town making this return)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ~~XXX~~ Della Roche
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 30 Jericho Hill Road St. Southborough, Mass. (City or town and State)

Length of stay: In place of death 14 years months days. In place of residence 78 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: January 19, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 5, 67, to January 19, 67
I last saw her alive on January 19, 67, death is said to have occurred on the date stated above, at m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Carcinomatosis — yrs
Due To
(b) carcinoma of rectum — yrs
Due To
(c)
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) Allen H. Knapp, M. D.

(Address) Westboro, Mass Date Jan. 19 67

Place of Burial or Cremation: Immaculate Conception; Marlboro, Mass. (City or Town)

DATE OF BURIAL: January 23 67

7 NAME OF FUNERAL DIRECTOR: John W. Sullivan

ADDRESS: 378 Lincoln St. Marlboro, Mass.

Received and filed February 6, 67

Eleanor F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	white	Single

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 78 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housekeeper (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 024-36-6747

16 BIRTHPLACE (City) (State or country) Southborough, Mass.

PARENTS

17 NAME OF FATHER: Martin Roche

18 BIRTHPLACE OF FATHER (City) (State or country): Ireland

19 MAIDEN NAME OF MOTHER: Nora Gilboyle

20 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

21 Informant: John Roche - brother

(Address) 30 Jericho Hill Rd. Southboro Mass.

A TRUE COPY
ATTEST: Peter P. Cottone
(Registrar of City or Town where death occurred)

Agent

DATE FILED Jan. 20, 1967

100M-5-64-938000

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH: WORCESTER (County); Westborough (City or Town); WESTBOROUGH (City or Town making this return); Registered No. .....

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Howard S. Hunt (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence No. 45 Highland St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 15 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 12, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully)

Natural Causes: Chronic Brain Syndrome and glomerulo-nephritis (Not on hospital danger list)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury ..... no

While at work? ..... Was autopsy performed? ..... no

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) S. Alden Guild, M.D., M. D.

(Address) Grafton, Mass. Feb. 12 67 Date, 19

7 Place of Burial or Cremation Rural Cemetery, Southboro, Mass. (City or Town)

DATE OF BURIAL February 15, 19 67

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St., Southboro, Mass.

Received and filed March 14 19 67

Eleanora F. Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

12 If married, widowed, or divorced
HUSBAND of Ida M. Liberty (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 AGE 83 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Retired (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. 028-16-4322A

17 BIRTHPLACE (City) (State or country) Sudbury, Mass.

PARENTS

18 NAME OF FATHER John Hunt

19 BIRTHPLACE OF FATHER (City) Sudbury, (State or country) Mass.

20 MAIDEN NAME OF MOTHER Nancy Glenn

21 BIRTHPLACE OF MOTHER (City) Kings County, N.S. (State or country) Canada

22 Informant (Address) Westborough State Hospital Records, Westborough, Mass.

A TRUE COPY
ATTEST: Annie R. Dunne (Registrar of City or Town where death occurred)

DATE FILED February 16, 19 67

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ida M. Greeley (Hayward)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. 99 Woodland Rd., St. Southboro, Mass. (City or town and State)

Length of stay: In place of death.....years 11 months.....days. In place of residence 16 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 12 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 1, 1967, to March 12, 67

I last saw her alive on March 11, 1967, death is said to have occurred on the date stated above, at 5:30am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Kidney Failure	7 dys.
Due To (b)	Metastatic carcinoma	10 mos.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? yes

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify no

(Signature) Melvin H. Sher, M. D.

(Address) Framingham Date 3/12/67 19....

6 Edgell Grove Cem. Framingham
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 14 19 67

7 NAME OF FUNERAL DIRECTOR Carl E. Willson

ADDRESS Framingham, Mass.

Received and filed April 5 19 67

Clarence F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	widow

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Walter E. Greeley
(Husband's name in full)

12 AGE 83 Years 6 Months 18 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 028-22-8918T

16 BIRTHPLACE (City) (State or country) Stow, Mass.

PARENTS

17 NAME OF FATHER George Hayward

18 BIRTHPLACE OF FATHER (City) (State or country) Boxboro, Mass.

19 MAIDEN NAME OF MOTHER Eva Nealey

20 BIRTHPLACE OF MOTHER (City) (State or country) Concord, Mass.

21 Informant Mrs. Velma McLaughlin
99 Woodland Rd.,
(Address) Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED March 23, 1967 19....

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-9-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

NEWTON (City or Town making this return)

Registered No. 147-67

1 PLACE OF DEATH: MIDDLESEX (County); NEWTON (City or Town)

No. Newton-Wellesley Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Helen T. Fitzgerald
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 76 Marlboro Road St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death — years — months 2 days. In place of residence 50 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 22 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19 63, to March 22, 19 67
I last saw her alive on March 22, 19 67, death is said to have occurred on the date stated above, at 10:30A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral Edema and Anoxia	20 hrs
Due To (b)	Cardiac Arrest	20 hrs
Due To (c)	Carotid Body Tumor	
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? Yes
What test confirmed diagnosis? Yes

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...

(Signature) Gerald G. Garcelon, M. D.
(Address) 2000 Washington St. Newton Date Mar. 22, 19 67

6 Place of Burial ~~or Cremation~~ Immaculate Conception Cemetery (City or Town) Marlboro
DATE OF BURIAL March 27, 19 67

7 NAME OF FUNERAL DIRECTOR John Sullivan
ADDRESS 378 Lincoln St., Marlboro

Received and filed April 10 19 67
Theresa F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Female	White	Single

11 If married, widowed, or divorced
HUSBAND of ---- (Give maiden name of wife in full)
(or) WIFE of ---- (Husband's name in full)

12 AGE 64 Years 3 Months 17 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Retired - Accountant
(Kind of work done during most of working life)

14 Industry or Business: Dennison Manufacturing Co.

15 Social Security No. 019 - 10 - 0688

16 BIRTHPLACE (City) (State or country) Marlboro, Mass.

PARENTS

17 NAME OF FATHER: Andrew Fitzgerald

18 BIRTHPLACE OF FATHER (City) (State or country): Marlboro, Mass.

19 MAIDEN NAME OF MOTHER: Julia O'Connell

20 BIRTHPLACE OF MOTHER (City) (State or country): Marlboro, Mass.

21 Informant Miss Julia Fitzgerald
(Address) 76 Marlboro Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Joseph H. Kuhn
(Registrar of City or Town where death occurred)
DATE FILED March 23, 19 67

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-61-938000

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 8

No. Choate House 43 Main St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Marie-Antoinette (Lenfant) Wiseman
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. Choate House 43 Main St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death 15 years ..... months ..... days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 7 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxiation by Suspension, Suicidal.

5 Accident, suicide, or homicide (specify) Suicide

Date and hour of injury 7:10AM April 7 19 67

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) S. Alden Gould M.D., M. D.
S. Alden Gould M.D. (Print or Type Name)

(Address) Grafton Date April 7 19 67

7 Ruarl Cemetery Southboro, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL April 10 19 67

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St Southboro, Mass.

Received and filed April 12 19 67

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX F

10 COLOR White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Widowed

12 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of William Charles Eric Wiseman
(Husband's name in full)

13 AGE 63 Years 6 Months 2 Days
If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife & Teacher
(Kind of work done during most of working life)

15 Industry or Business: St. Marks School

16 Social Security No. 020-32-7929

17 BIRTHPLACE (City) Uzerche
(State or country) France

PARENTS

18 NAME OF FATHER Joseph Lenfant

19 BIRTHPLACE OF FATHER (City) CNBL
(State or country) France

20 MAIDEN NAME OF MOTHER Anne Sagarde

21 BIRTHPLACE OF MOTHER (City) CNBL
(State or country) France

22 Informant (Address) J.S. Sheppard
St. Marks School Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Sina A. Concolette Asst.
(Signature of Agent of Board of Health or other)

4-9-67
(Official Designation) (Date of Issue of Permit)

MEDICAL

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 10

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); ..... (City or Town making this return)

No. Ritas Beauty Salon 37 E. Main St. St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary (Eagan) McCann
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. 36 Boston Road St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 12 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Natural causes: Heart disease presumably myocardial infarction (Sudden death)

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) S. Aldo Ruiel, M. D.
S. Aldo Ruiel M.D
(Print or Type Name)
(Address) Grafton Date Apr. 13 1967

7 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL April 15, 1967

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS 40 Main St. Southboro, Mass.

Received and filed April 21 1967
Eleanor F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
F	White	Widowed

12 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Hugh T. McCann Sr (Husband's name in full)

13 AGE 67 Years 11 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: at home

16 Social Security No. 020-28-9579

17 BIRTHPLACE (City) Somerset (State or country) Mass

PARENTS

18 NAME OF FATHER Patrick Eagan

19 BIRTHPLACE OF FATHER (City) Somerset (State or country) Mass

20 MAIDEN NAME OF MOTHER Margaret Flanagan

21 BIRTHPLACE OF MOTHER (City) Taunton (State or country) Mass

22 Informant (Address) Hugh T. McCann Jr
36 Boston Road, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sima A Tocalette.
(Signature of Agent of Board of Health or other)

(Official Designation) 4-15-67 (Date of Issue of Permit)

ORM R-303

filed for burial permit
h Board of Health
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 9

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
Southboro (City or Town making this return)

No. 5 Redgate Lane St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John (First Name) (Middle Name) Stepanoff (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 5 Redgate Lane St. Southboro (City or town and State)

Length of stay: In place of death 6 years ... months ... days. In place of residence 6 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 12 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Natural causes: Heart disease, pre-sumably myocardial infarction (found dead in bed)

5 Accident, suicide, or homicide (specify) ...
Date and hour of injury ... 19...
IF ACCIDENTAL, was injury causally related to the death? ...
Where did Injury occur? ... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ... (Specify type of place)
Manner of Injury ... (How did injury occur?)
Nature of Injury ...
While at work? ... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify ...

(Signed) S. Alden Gould, M. D.
S. Alden Gould MD (Print or Type Name)
(Address) Grafton Date April 12 19 67

7 Holy Trinity Monastery Cem. Jordanville, N.Y. Place of Burial or Cremation. (City or Town)
DATE OF BURIAL April 15, 19 67

8 NAME OF FUNERAL DIRECTOR Henry Funeral Service, by Henry V. Karolkiewicz
ADDRESS 33 Ward St., Worcester, Mass.

Received and filed April 14 19 67
Louise F. Burke (Registrar)
A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Male	White	Married

12 If married, widowed, or divorced
HUSBAND of Alexandra Oulessoff (Give maiden name of wife in full)
(or) WIFE of ... (Husband's name in full)

13 AGE 79 Years 1 Months 2 Days — If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Laborer (Kind of work done during most of working life)

15 Industry or Business: Self employed

16 Social Security No. 028-28-9591

17 BIRTHPLACE (City) (State or country) Russia

PARENTS

18 NAME OF FATHER Basil Stepanoff

19 BIRTHPLACE OF FATHER (City) (State or country) Russia

20 MAIDEN NAME OF MOTHER Havoronia (Not learned)

21 BIRTHPLACE OF MOTHER (City) (State or country) Russia

22 Informant (Address) Alexandra Stepanoff (Wife), 5 Redgate Lane, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sara A Macaletti Agt
(Signature of Agent of Board of Health or other)
(Official Designation)

4/14/67
(Date of Issue of Permit)

MEDICAL

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — MARGIN RESERVED FOR BINDING

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ralph Shedd (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. White Bagley Rd. St. Southboro, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 23 days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 7, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1967, to May 7, 1967

I last saw him alive on May 6, 1967, death is said to have occurred on the date stated above, at 9.45P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of l. kidney, Metastatic — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Surgery & Biopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) Robert E. Johnson, M. D.

(Address) Framingham Date 5/8 1967

6 Evergreen Cem., New Braintree (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL May 10 1967

7 NAME OF FUNERAL DIRECTOR Donald Morris

ADDRESS Southboro, Mass.

Received and filed May 29, 1967

Edward T. Barber (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Helen Webb (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 74 Years 2 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Maintanance (Kind of work done during most of working life)

14 Industry or Business: Fram. Union Hospital

15 Social Security No. 020-26-4297

16 BIRTHPLACE (City) (State or country) New Braintree, Mass.

PARENTS

17 NAME OF FATHER: Jonas T. Shedd

18 BIRTHPLACE OF FATHER (City) (State or country): Oakham, Mass.

19 MAIDEN NAME OF MOTHER: Mary Proctor

20 BIRTHPLACE OF MOTHER (City) (State or country): Sioux City, Iowa

21 Informant: Mrs. Helen Shedd
(Address) White Bagley Rd. Southboro, Mass.

A TRUE COPY
ATTEST: Vincent J. Ward
(Registrar of City or Town where death occurred)

DATE FILED May 17 1967

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

11

Marlborough (Registration District of this return)

Registered No. 124

1 PLACE OF DEATH: Middlesex (County) — Marlborough (City or Town)

No. Braemoor Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Josephine M. (Nicol) Michel (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. Middle Road St. Southboro, Mass (Town and State)

Length of stay: In place of death 4 years ..... months ..... days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: May (Month) 9, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 64, to May 9 67

I last saw her alive on May 9 67, death is said to have occurred on the date stated above, at 3.00a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: yrs.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical findings

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) Arthur G. Richer, M. D.

(Address) Hudson, Mass Date May 10 19 67

Place of Burial or Cremation St. Mary's Cem. Marlboro, Mass. (City or Town)

DATE OF BURIAL May 12 19 67

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed May 17, 67

Eleanor F Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Female	White	Widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Henry H. Michel (Husband's name in full)

12 AGE 86 Years 4 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: House wife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) St. Germaine P.Q. Canada

PARENTS

17 NAME OF FATHER Octave Nicol

18 BIRTHPLACE OF FATHER (City) (State or country) St. Germaine P.Q. Canada

19 MAIDEN NAME OF MOTHER Celina LaFontaine

20 BIRTHPLACE OF MOTHER (City) (State or country) St. Germaine P.Q. Canada

21 Informant Mrs. Rietha Baker

(Address) Middle Rd. Southboro, Mass.

A TRUE COPY. Attest: Rita A. Lapsine

ATTEST: Peter P. Cott (Registrar of City or Town where death occurred)

Issued May 10, 1967 19

Agent

100M-5-6L-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 13

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. 71 School St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Louise Rose (Castagnetti) Bertonazzi
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. 71 School St St. Southboro, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 50 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: June (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from A FEB, 1948, to 1 JUN, 1967

I last saw her alive on 16 MAY, 1967, death is said to have occurred on the date stated above, at 10.00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 1/2 yrs

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS: Diabetes Mellitus — 3 3/4 yrs
Cerebral Thrombosis — 3 1/2 mos

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL COURSE

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify —

(Signature) Timothy P. Stone, M. D.
TIMOTHY P STONE
(Print or Type Name)
(Address) 42 MAIN, SOUTHBORO Date JUN 3 1967

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 5, 1967

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS 40 Main St. Southboro, Mass.

Received and filed June 7 1967
Clarence F. Burke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Louis C. Bertonazzi
(Husband's name in full)

12 AGE 76 Years 8 Months 21 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at Home

15 Social Security No. 026-20-0823

16 BIRTHPLACE (City or town) Piacenza (State or country) Italy

PARENTS

17 NAME OF FATHER: Joseph Castagnetti

18 BIRTHPLACE OF FATHER (City) Piacenza (State or country) Italy

19 MAIDEN NAME OF MOTHER: Katharina Ponticello

20 BIRTHPLACE OF MOTHER (City) Piacenza (State or country) Italy

21 Informant Mrs. Angie Ostresh
(Address) 71 School St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jno. C. A. Tomaselotti
(Signature of Agent of Board of Health or other)

(Official Designation) June 3 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

ORM R-303

filed for burial permit
h Board of Health
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-61-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 14

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

No. 7 Maple Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Louise (First Name) DeLarda (Middle Name) DeLarda (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 7 Maple Street St. Southboro, Mass. (City or town and State)

Length of stay: In place of death 30 years ... months ... days. In place of residence 30 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 6 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease
presumably myocardial infarction
(Sudden death)

5 Accident, suicide, or homicide (specify) ...

Date and hour of injury ... 19...

IF ACCIDENTAL, was injury causally related to the death? ...

Where did Injury occur? ... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ... (Specify type of place)

Manner of Injury ... (How did injury occur?)

Nature of Injury ...

While at work? ... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) S. Alden Gurd, M. D.

S. Alden Gurd M.D. (Print or Type Name)

(Address) Grafton Date July 7 19 67

7 Rural Cemetery Southboro, Mass. Place of Burial or Cremation. (City or Town)

DATE OF BURIAL July 10 19 67

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 main St. Southboro Mass.

Received and filed July 12, 19 67

Edward T. Burke (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
F	White	Married

12 If married, widowed, or divorced
HUSBAND of ... (Give maiden name of wife in full)
(or) WIFE of Henry J. Delarda (Husband's name in full)

13 AGE 59 Years 6 Months 22 Days | If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Sales Lady (Kind of work done during most of working life)

15 Industry or Business: Jordan Marsh Co

16 Social Security No. 017-07-6686

17 BIRTHPLACE (City) Clinton (State or country) Mass.

PARENTS

18 NAME OF FATHER Joseph Tansey

19 BIRTHPLACE OF FATHER (City) Parma (State or country) Italy

20 MAIDEN NAME OF MOTHER Modesta Sori

21 BIRTHPLACE OF MOTHER (City) Parma (State or country) Italy

22 Informant Henry J. Delarda
(Address) 7 Maple St. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs Sina A Moralette Agent
(Signature of Agent of Board of Health or other)

(Official Designation)

7-10-67
(Date of Issue of Permit)

MEDICAL

1843

R-303

or burial permit
rd of Health
Agent.

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WORCESTER
(City or Town making return)

Registered No. 12[illegible]

PLACE OF DEATH

1 (County) Worcester

(City or Town) Worcester

No. St. Vincent Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James Daughan
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 26 Latisquama Road St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 67 years 6 months 20 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 27 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

cardiac arrest

5 Accident, suicide, or homicide (specify) no

Date and hour of injury ..... 19—

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? Worcester Mass
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? no
(Specify type of place)

Manner of Injury (How did injury occur?) died in operating room of heart attack

Nature of Injury cardiac arrest

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John C. Ward, M. D.

(Print or Type Name)

(Address) 275 Main Date July 28 67

7 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL July 31 19 67

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 10 Main St Southboro, Mass.

Received and filed AUG 1 1967 19

A TRUE COPY ATTEST: Robert J. O'Keefe (Registrar)

Rec'vd. 8/11/67

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M

10 COLOR White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (Write word)

12 If married, widowed, or divorced
HUSBAND of Marguerite Gobeille
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

13 AGE 67 Years 6 Months 20 Days If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Civil Engineer
(Kind of work done during most of working life)

15 Industry or Business: Whitman & Howard

16 Social Security No. 022-16-0270

17 BIRTHPLACE (City) Southboro, Mass
(State or Country)

18 NAME OF FATHER Daniel Daughan

19 BIRTHPLACE OF FATHER (City) (County Armigh)
(State or country) Ireland

20 MAIDEN NAME OF MOTHER Elizabeth Hannon

21 BIRTHPLACE OF MOTHER (City) (Tipperary)
(State or country) Ireland

PARENTS

22 Informant (Address) Mrs. James M. Daughan
26 Latisquama Road
Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Kenneth S. Mackie, M.D.
(Signature of Agent of Board of Health or other)
Commissioner of Public Health
(Official Designation)

Aug 1 67
(Date of Issue of Permit)

OFFICIAL COPY

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46 §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L., Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

1843
M R-303

for burial permit
ard of Health
ts Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 28; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WORCESTER
(City or Town making this return)

Registered No. 1855

PLACE OF DEATH

1 Worcester (County)
Worcester (City or Town)
No. St. Vincent Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) WW I

2 FULL NAME James Daughan
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 26 Latisquama Road St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death ___ years ___ months 2 days. In place of residence 67 years 6 months 20 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 27 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

cardiac arrest

5 Accident, suicide, or homicide (specify) ne

Date and hour of injury ___ 19__

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? Worcester Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? no (Specify type of place)

Manner of Injury fell operating room table (How did injury occur?)

Nature of Injury cardiac arrest

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John C. Ward M. D.

John C. Ward (Print or Type Name)

(Address) 93 Irving Date July 28 67

7 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL July 31 19 67

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 10 Main St Southboro, Mass.

Received and filed AUG 1 1967 19

A TRUE COPY ATTEST: Robert J. O'Kane (Registrar)

Rec'd August 11, 1967 Clarence Burke

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
M	White	Married

12 If married, widowed, or divorced
HUSBAND of Marguerite Gobeille
(Give maiden name of wife in full)
(or) WIFE of ___
(Husband's name in full)

13 AGE 67 Years 6 Months 20 Days | If under 24 hours ___ Hours ___ Minutes

14 Usual Occupation: Civil Engineer
(Kind of work done during most of working life)

15 Industry or Business: Whitman & Howard

16 Social Security No. 022-16-0270

17 BIRTHPLACE (City) (State or Country) Southboro, Mass

PARENTS

18 NAME OF FATHER Daniel M. Daughan

19 BIRTHPLACE OF FATHER (City) (State or country) (County Armigh) Ireland

20 MAIDEN NAME OF MOTHER Elizabeth Hannon

21 BIRTHPLACE OF MOTHER (City) (State or country) (Tipperary) Ireland

22 Informant Mrs. James M. Daughan
(Address) 26 Latisquama Road Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death has been filed with me (REVISED) and the burial or transit permit was issued:

Kenneth E. MacLeod, M.D.
(Signature of Agent of Board of Health or other)
Commissioner of Public Health
(Official Designation)

7/29/67
(Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough
(City or Town making this return)

Registered No. 203

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Braemoor Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Brusie (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) ----

(a) Permanent Residence. No. Turnpike Road St. Southborough, Mass. (City or town and State)

Length of stay: In place of death 1 year 3 months ..... days. In place of residence 85 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: July 28, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 21 19 67 to July 28 19 67

I last saw him alive on July 28 19 67, death is said to have occurred on the date stated above, at 10:10 am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral hemorrhage	7 das
Due To (b)	Cerebral vascular disease	10 yrs
Due To (c)	C.H. Failure	5 das
OTHER SIGNIFICANT CONDITIONS	Broncho pneumonia	4 das

Was autopsy performed? no

What test confirmed diagnosis? usual

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) D. Fiorentino, M. D.

(Address) Marlboro, Mass. Date 7-28 67

6 Rural Cemetery; Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 1 67

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed August 1, 67

Theresa F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Male	White	Widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 86 Years 4 Months 0 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired (Kind of work done during most of working life)

14 Industry or Business: Shoe Industry

15 Social Security No. 025-18-1306

16 BIRTHPLACE (City) (State or country) Piacenza, Italy

PARENTS

17 NAME OF FATHER: Joseph Brusie

18 BIRTHPLACE OF FATHER (City) (State or country): Piacenza, Italy

19 MAIDEN NAME OF MOTHER: Maria Losi

20 BIRTHPLACE OF MOTHER (City) (State or country): Piacenza, Italy

21 Informant: Mrs. Rose Francione

(Address) 26 Vine St. Marlboro, Mass.

A TRUE COPY: Peter P. Cotone
ATTEST: Agent (Registrar of City or Town where death occurred)

DATE FILED July 29, 1967

100M-5-64-938000

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

17

Framingham
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH

Middlesex
(County)

Framingham
(City or Town)

No. Framingham UnionHospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Muriel Curtis (Hunt)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 7 Newton St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death ..... years ..... months 9 days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 29, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Dec. 18, 19 54 to July 29, 19 67

I last saw her alive on July 29, 19 67, death is said to have occurred on the date stated above, at 8:45P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Emphysema	8 yrs.
Due To (b)	Chronic bronchitis	12yrs.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Arteriosclerotic heart disease	2 yrs.

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 7/31 19 67

6 Rural Cem., Worcester, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 1 19 67

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed August 4, 19 67

Edward J. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Female	white	widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Edward A. Curtis
(Husband's name in full)

12 AGE 83 Years ..... Months 10 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Seamstress
(Kind of work done during most of working life)

14 Industry or Business: Private School

15 Social Security No. 021-28-2709

16 BIRTHPLACE (City) Newton, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Henry C. Hunt

18 BIRTHPLACE OF FATHER (City) Boston, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Mary E. Wiggin

20 BIRTHPLACE OF MOTHER (City) Boston, Mass.
(State or country)

21 Informant Mrs. Betty C. Dudgley
(Address) 2A Myrtle st. Westboro, Mass.

A TRUE COPY
ATTEST: Michael J. Lisbon
(Registrar of City or Town where death occurred)

DATE FILED July 31 19 67

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH
Middlesex (County)
Framingham (City or Town)
No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sumner W. Elton
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Permanent Residence. No. 9 Cordaville Rd., St. Southboro, Mass. (City or town and State)

Length of stay: In place of death 2 days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 5 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 12 59, to August 5 67, I last saw him alive on August 4 67, death is said to have occurred on the date stated above, at 9:05 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Bronchogenic carcinoma	4 mons.
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? yes autopsy
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Timothy P. Stone, M. D.
(Address) Southboro Date 8/6/67 19.....

6 Rural Cem., Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL August 8 67 19.....

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS Southboro, Mass.

Received and filed September 1, 1967 19.....
Leonard T. Barker
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
male	white	married

11 If married, widowed, or divorced HUSBAND of Flora G. Brown
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 61 Years 8 Months 17 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Attorney
(Kind of work done during most of working life)

14 Industry or Business: Law Profession

15 Social Security No. 021-01-8162

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

PARENTS

17 NAME OF FATHER William J. Elton

18 BIRTHPLACE OF FATHER (City) .....
(State or country) England

19 MAIDEN NAME OF MOTHER Bertha F. Wilder

20 BIRTHPLACE OF MOTHER (City) Boston, Mass.
(State or country)

21 Informant Mrs. Sumner W. Elton
(Address) 9 Cordaville Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Michael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED August 8, 1967 19.....

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... August 9, 1941 .....

DATE OF DISCHARGE ..... October 14, 1946 .....

RANK, RATING ..... Colonel .....

ORGANIZATION AND OUTFIT ..... Judge Advocate Trinidad BWI Base Command .....

SERVICE NUMBER ..... 024-363 .....

.....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

21

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret Leland (Carr) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. Main St., St. Southboro, Mass. (City or town and State)

Length of stay: In place of death 4 days. In place of residence 59 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 9 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 6, 1967, to August 9, 1967. I last saw her alive on August 9, 67, death is said to have occurred on the date stated above, at 7 pm m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Obstructive jaundice — 2 wks

Due To (b) Gall stones — 3 yrs.

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS Pneumonia — 2 dys.

Was autopsy performed? yes

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) Charles Peabody, M. D.

(Address) Framingham Date 8/9/67 19.....

6 Edgell Grove Cem., Framingham (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL August 12 1967

7 NAME OF FUNERAL DIRECTOR J. S. Waterman & Sons

ADDRESS Wellesley, Mass.

Received and filed September 1, 1967

Eleanor F. Berkey

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Charles F. Leland (Husband's name in full)

12 AGE 82 Years 2 Months 15 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 033 34 9592

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Samuel Carr

18 BIRTHPLACE OF FATHER (City) Newburyport, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Susan Waters

20 BIRTHPLACE OF MOTHER (City) Newburyport, (State or country) Mass.

21 Informant Franz Denghausen
(Address) Main St., Southboro, Mass.

A TRUE COPY
ATTEST: Rachael J. Ward
(Registrar of City or Town where death occurred)

DATE FILED Aug. 14, 1967

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 214

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clarence Edward Baker* (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 100 Newton St. Southboro, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 67 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 11, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from August, 1958, to August 11, 1967

I last saw him alive on August 11, 67, death is said to have occurred on the date stated above, at 2.20p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs

Due To (b) arteriosclerosis — yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) John D. Nicholson, M. D.

(Address) Sudbury, Mass Date Aug 11 67

Rural Cemetery, Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 14 67

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Received and filed August 15 1967 19

August 28, 1967

Eleanor F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Married *

11 If married, widowed, or divorced
HUSBAND of Mary Alderson (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 67 Years 7 Months 0 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Welder & Water Dept. Supt. (Kind of work done during most of working life)

14 Industry or Business: Town of Southboro

15 Social Security No. 028-26-8907

16 BIRTHPLACE (City) (State or country) Everett, Mass.

PARENTS

17 NAME OF FATHER Frank K. Veazie

18 BIRTHPLACE OF FATHER (City) (State or country) Everett, Mass.

19 MAIDEN NAME OF MOTHER Beulah King

20 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

21 Informant Mrs. C. Edward Baker

(Address) 100 Newton St. Southboro, Mass

A TRUE COPY Attest: Lisa A. Lapsise

ATTEST: Peter P. Cottone
(Registrar of City or Town where death occurred)

Agent DATE FILED August 14, 1967 19

Baker was adopted - difference in father's name

100M-5-64-938000

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Waltham
(City or Town making this return)

Registered No. 498

1 PLACE OF DEATH
Middlesex (County)
Waltham (City or Town)
No. Waltham Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ronald C. Yorston
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) WW 2

(a) Permanent Residence. No. Prentiss St. Southboro, Mass.
(City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 16, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 25, 1967, to August 16, 1967
I last saw him alive on August 16, 1967, death is said to have occurred on the date stated above, at 5:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Acute posterior myocardial infarction.	8 wks
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? yes
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) John C. Wells, Jr., M. D.

(Address) Weston, Mass. Date 8-16-1967

6 Calvary Waltham
Place of Burial or Cremation (City or Town)
DATE OF BURIAL August 19, 1967

7 NAME OF FUNERAL DIRECTOR F.J.Joyce and Son
ADDRESS Waltham, Mass.

Received and filed Sept. 6, 1967
Eleanor F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
Male	White	Married

11 If married, widowed, or divorced HUSBAND of Leonora Andrews
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 19 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Exterminator
(Kind of work done during most of working life)

14 Industry or Business: Minute Man Chemical Co.

15 Social Security No. 025-05-7092

16 BIRTHPLACE (City) (State or country) Georgetown PEI Canada

PARENTS

17 NAME OF FATHER Joseph Yorston

18 BIRTHPLACE OF FATHER (City) (State or country) Prince Edward Island Canada

19 MAIDEN NAME OF MOTHER Mary Steele

20 BIRTHPLACE OF MOTHER (City) (State or country) Prince Edward Island Canada

21 Informant Mrs. Leonora Yorston (wife)
(Address) Prentiss St., Southboro

A TRUE COPY
ATTEST: William J. Lanagan
(Registrar of City or Town where death occurred)

DATE FILED August 18, 1967

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 9/26/42

DATE OF DISCHARGE 11/7/45

RANK, RATING Tec 4

ORGANIZATION AND OUTFIT 51st Station Hospital, U.S.Army

SERVICE NUMBER 31 084 232

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N.B.— WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, Sec. 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936348

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

OUT - OF - TOWN

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 025899

No. New England Med Center St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ottone (First Name) Oddono (Middle Name) Piazza (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 116 Pine Hill Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Acute Hepatic Necrosis

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? YES

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Geo W. Curtis, M. D.

Gdorge W. Curtis, M. D. (Print or Type Name)

(Address) 784 Mass Date Aug 20 1967

7 Woodlawn Cemetery, Everett (City or Town)
Place of Burial or Cremation.

DATE OF BURIAL August 22, 1967

8 NAME OF FUNERAL DIRECTOR J. S. Waterman & Sons

ADDRESS Boston Mass

Received and filed AUG 23 1967

A TRUE COPY ATTEST: Thomas F. Burke (Registrar)

October 30, 1967

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Male	White	Widdowed

12 If married, widowed, or divorced
HUSBAND of Maria Sacchi (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

13 AGE 58 Years 8 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Dog trainer (Kind of work done during most of working life)

15 Industry or Business: own business

16 Social Security No. none

17 BIRTHPLACE (City) (State or country) Italy

PARENTS

18 NAME OF FATHER Cannot be learned Piazza

19 BIRTHPLACE OF FATHER (City) (State or country) Italy

20 MAIDEN NAME OF MOTHER Cannot be learned

21 BIRTHPLACE OF MOTHER (City) (State or country) Italy

22 Informant Miss Paola Piazza
(Address) 116 Pine Hill Road, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F. E. Lucca E 13764
(Signature of Agent of Board of Health or other)

(Official Designation) Aug. 21, 1967 (Date of Issue of Permit)

VOID

FORM R-305

MAKE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

18

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough (City or Town making this return)

Registered No. 223

PLACE OF DEATH

1 Middlesex (County)

Marlborough (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary (Hakim) Zkiab (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 8 Mitchell St. Southborough, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 19, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

heart disease, presumably
coronary sclerosis
(sudden death)

5 Accident, suicide, or homicide (specify) none

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) R. N Rittenhouse, M. D.

640 Bolton St.

(Address) Marlboro, Mass Date Aug. 19 67

7 Southboro Cemetery, Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 22 67

8 NAME OF FUNERAL DIRECTOR Carroll-Thomas

ADDRESS Hyde Park, Mass.

Received and filed August 21 67

August 28, 1967 Gloria F. Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Norman J. Zkiab
(Husband's name in full)

13 AGE 60 Years.....Months.....Days If under 24 hours .....Hours .....Minutes

14 Usual Occupation: Stitcher (Kind of work done during most of working life)

15 Industry or Business: Corban Shoe Co.

16 Social Security No. 022-10-0831

17 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

18 NAME OF FATHER Najeeb Hakim

19 BIRTHPLACE OF FATHER (City) (State or country) Beruit, Lebanon

20 MAIDEN NAME OF MOTHER Sophie Kiswanee

21 BIRTHPLACE OF MOTHER (City) (State or country) Beruit, Lebanon

22 Informant Norman J. Zkiab
(Address) 8 Mitchell St. Southboro, Mass.

A TRUE COPY Lida A. Lapine
ATTEST: Peter P. Cottone
(Registrar of City or Town where death occurred)

Agent
DATE FILED Aug. 21, 1967

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

23

Registered No. 56

1 PLACE OF DEATH
Worcester (County)
Northboro (City or Town)
Northborough (City or Town making this return)
No. Green Acres Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ethel (Gage) Hobart
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 7 Newton Street St. Southboro, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 23 (Month) (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6 Sept., 1966, to 23 Sept., 1967
I last saw her alive on 21 Sept., 1967 death is said to have occurred on the date stated above, at 4:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral thrombosis	2 days
Due To (b) Arteriosclerosis	-
Due To (c) -	
OTHER SIGNIFICANT CONDITIONS Inanition	6 mos.

Was autopsy performed? No
What test confirmed diagnosis? Clinical State

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Timothy P. Stone, M. D.
(Address) 42 Main Southboro Date 24 Sept., 1967

6 Rural Crematory Worcester, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 26, 1967

7 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS 40 Main St. Southboro, Mass.

Received and filed October 6, 1967
Theresa F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED, WIDOWED, DIVORCED UNKNOWN
Female	white	Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Parker Hobart
(Husband's name in full)

12 AGE 87 Years 9 Months 9 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 016-14-3702

16 BIRTHPLACE (City) Braintree (State or country) Mass.

PARENTS

17 NAME OF FATHER R. Allen Gage

18 BIRTHPLACE OF FATHER (City) Braintree (State or country) Mass.

19 MAIDEN NAME OF MOTHER Hattie Holbrook

20 BIRTHPLACE OF MOTHER (City) Braintree (State or country) Mass.

21 Informant Mrs. Herbert Lowe
(Address) 326 Main St. Oxford, Mass.

A TRUE COPY
ATTEST: Marion B. Flynn
(Registrar of City or Town where death occurred)
DATE FILED September 27, 1967

2

.2488

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 4, 29; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936308

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WORCESTER (City or Town making this return)

Registered No. 2560

PLACE OF DEATH

1 (County) Worcester

(City or Town) Worcester

The Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

No. Pamela Ann Misener St.

2 FULL NAME Pamela ann Misener
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. 8 Latiquama Rd St. Southboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 25 minutes days. In place of residence 4 years ..... months 17 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 20 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

fracture of skull
brain injury

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 4 pm Oct 20 1967

IF ACCIDENTAL, was injury causally related to the death? yes

Where did Injury occur? Southboro Mass
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? street
(Specify type of place)

Manner of Injury struck by auto
(How did injury occur?)

Nature of Injury fracture of skull - brain injury

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) [signature], M. D.

JOHN C WARD
(Print or type Name)

(Address) 978 Main Date Oct 20 1967

7 Rural Cemetery Southboro Mass
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Oct. 23. 1967

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 main St. Southboro, Mass.

Received and filed OCT 24 1967 [signature]

A TRUE COPY ATTEST: [signature] November 27 1967 (Registrar) (Date of Issue of Permit)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
F	White	Single

12 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 AGE 4 Years ..... Months 17 Days ..... If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: at home (Kind of work done during most of working life)

15 Industry or Business: None

16 Social Security No. None

17 BIRTHPLACE (City) (State or country) Marlboro Mass.

PARENTS

18 NAME OF FATHER John C. Misener

19 BIRTHPLACE OF FATHER (City) Framingham (State or country) Mass.

20 MAIDEN NAME OF MOTHER Joan Damico

21 BIRTHPLACE OF MOTHER (City) Marlboro, Mass. (State or country) Mass.

22 Informant John C. Misener (Address) 8 Latiquama Rd, Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature] M.D.
(Signature of Agent of Board of Health or Other) Commissioner of Public Health

Oct 21, 1967 (Date of Issue of Permit)

178

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. .....

(City or Town making this return)

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. ..... St. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mark S Gignac
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Permanent Residence. No. 44 Lattisquama Road St. Southboro, Massachusetts (City or town and State)

Length of stay: In place of death 1 years 6 months ..... days. In place of residence 1 years 6 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 2 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Diffuse interstitial pneumonitis
and cerebral edema (Sudden death)

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19..

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) S. Alden Guild, M.D., M. D.
S. Alden Guild, M.D.
(Print or Type Name)

(Address) Grafton Date ..... 19..

7 Rural Cemetery, Southboro
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL November 4 67 19..

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS 40 Main St., Southboro

Received and filed November 30 19 67
Eleanor F. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
male	white	single

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE 4 Years 9 Months 6 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: at home
(Kind of work done during most of working life)

15 Industry or Business: at home

16 Social Security No. none

17 BIRTHPLACE (City) Norwood, Massachusetts
(State or country)

PARENTS

18 NAME OF FATHER John D. Gignac

19 BIRTHPLACE OF FATHER (City) Franklin
(State or country) New Hampshire

20 MAIDEN NAME OF MOTHER Joanne Tartaglino

21 BIRTHPLACE OF MOTHER (City) Newport
(State or country) Rhode Island

22 Informant (Address) John D. Gignac -Father
44 Lattisquama Road,
Southboro, Massachusetts

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

MEDICAL

FORM R-303

e filed for burial permit
vith Board of Health
or its Agent.

NOTE: CHAPTER 137, ACTS OF 1934, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. 44 Latisquama Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mark Stephen Gignac
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. 44 Latisquama Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 6 months ..... days. In place of residence 1 years 6 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 2 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Under investigation

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19.....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
(How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) S. Alden Smith
S. Alden Gould M.D.
(Print or Type Name), M. D.

(Address) Grafton Date Nov 2 1967

7 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL Nov. 4, 1967

8 NAME OF FUNERAL DIRECTOR Donald C. Morris
ADDRESS 40 main St. Southboro, Mass.

Received and filed November 13 1967
Theresa J. Burke
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
M	White	Single

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE 4 Years 9 Months 6 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: at home
(Kind of work done during most of working life)

15 Industry or Business: at home

16 Social Security No. None

17 BIRTHPLACE (City) Norwood
(State or country) Mass.

PARENTS

18 NAME OF FATHER John D. Gignac

19 BIRTHPLACE OF FATHER (City) Franklin
(State or country) N.H.

20 MAIDEN NAME OF MOTHER Joanne Tartaglino

21 BIRTHPLACE OF MOTHER (City) Newport
(State or country) R.I.

22 Informant John D. Gignac
(Address) 44 Latisquama Rd. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Anna Susan A. Tocalello Asst
(Signature of Agent of Board of Health or other)

(Official Designation) 11-3-67 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ferdinand L. Even, Sr. (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Permanent Residence. No. 128 Woodland Rd., St. Southboro (City or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 4 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 5 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 31, 1964, to November 5, 1967

I last saw him alive on November 4, 1967, death is said to have occurred on the date stated above, at 3.45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Duodenal ulcer — 6 wk

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS: Hemorrhage — 15 dys.; Cirrhosis — 9 mons.

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 11/6/67 19.....

6 Rural Crematory Worcester
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 7 67

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed November 24, 1967 19.....

Clarence F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
male	white	married

11 If married, widowed, or divorced
HUSBAND of Jennie L. Grizzard (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 49 Years 8 Months 20 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Salesman (Kind of work done during most of working life)

14 Industry or Business: Bakery

15 Social Security No. 036-03-0755

16 BIRTHPLACE (City) (State or country) Central Fall, R.I.

PARENTS

17 NAME OF FATHER Edie Even

18 BIRTHPLACE OF FATHER (City) (State or country) Belgium

19 MAIDEN NAME OF MOTHER Juliette Collignon

20 BIRTHPLACE OF MOTHER (City) (State or country) Belgium

21 Informant Mrs. Jonnie L. Even

(Address) 128 Woodland Rd., Southboro, Mass.

A TRUE COPY
ATTEST: Richard L. Wade
(Registrar of City or Town where death occurred)

DATE FILED November 9 19 67

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... October 1, 1942

DATE OF DISCHARGE ..... April 23, 1943

RANK, RATING ..... Apprentice Seaman

ORGANIZATION AND OUTFIT ..... USN

SERVICE NUMBER 204-93-63

.....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ferdinand L. Even, Sr. (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Permanent Residence. No. 128 Woodland Road St. Southboro, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 4 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 5 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 31, 1964 to November 5, 1967

I last saw him alive on November 4, 1967 death is said to have occurred on the date stated above, at 3:45 am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Duodenal ulcer	6 wk
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Hemorrhage Cirrhosis	5 dy 9 mons

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 11/6/ 1967

6 Rural Crematory worcester
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 7 1967

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

Received and filed November 9 1967

June 20, 1968 [illegible]
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
male	white	married

11 If married, widowed, or divorced
HUSBAND of Jennie L. Grizzard (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 49 Years 8 Months 20 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Salesman (Kind of work done during most of working life)

14 Industry or Business: Bakery

15 Social Security No. 036-03-0755

16 BIRTHPLACE (City) (State or country) Central Falls, R.I.

PARENTS

17 NAME OF FATHER Edie Even

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Belgium

19 MAIDEN NAME OF MOTHER Juliette Collignon

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Belgium

21 Informant Mrs. Jennie L. Even

(Address) 128 Woodland Rd., Southboro, Mass.

A TRUE COPY Michael J. Ward

ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED Nov. 9, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 10/1/1942

DATE OF DISCHARGE 4/23/1943

RANK, RATING ..... Apprentice seaman

ORGANIZATION AND OUTFIT ..... U.S. N.

SERVICE NUMBER 204-93-63

.....

CERTIFICATE OF DEATH
STATE OF VERMONT

DH-VS-5-7M-65

Certificate No.....

Please type (except signature) or write plainly with unfading ink. This is a Permanent Record. Do not use a ball point pen.

1. FULL NAME OF DECEASED (First) (Middle) (Last): Alton B. Spurr
2. DATE OF DEATH (Month) (Day) (Year): November 23, 1967
3. PLACE OF DEATH
   a. COUNTY: Windham
   b. CITY OR TOWN (If rural, please state): Brattleboro
   c. LENGTH OF STAY (In this place): Dead on arrival
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brattleboro Memorial Hospital
4. USUAL RESIDENCE (If institution—residence before admission)
   a. STATE: Massachusetts
   b. COUNTY: Worcester
   c. CITY OR TOWN (If rural, please state): Southboro
   d. STREET ADDRESS (If rural, give R. F. D. number): Lyman Street
5. SEX: Male
6. COLOR OR RACE: White
7. MARITAL STATUS (Check one): S ☐ M ☒ W ☐ D ☐
8. DATE OF BIRTH: Dec 22, 1904
9. AGE (In years last birthday): 62
   If under 1 year: Months / Days
   If under 24 hrs.: Hours / Mins.
10a. USUAL OCCUPATION (Kind of work done most of working life): Safety Engineer
10b. BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE: Southboro, Mass.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Harry Spurr
15. MOTHER'S MAIDEN NAME: ~~Marjorie Newton~~ Eva Bunnd
14. FATHER'S BIRTHPLACE (Town) (State or Country): Tonbrook, Nova Scotia
16. MOTHER'S BIRTHPLACE (Town) (State or Country): Southboro, Mass.
17. NAME OF HUSBAND OR WIFE: Marjorie Newton Spurr
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (Give war & dates of service): No
19. SOCIAL SECURITY NO.: 011-20-2745
20. INFORMANT'S NAME (Person giving this information): Mrs. Alton Spurr

21. Medical Certification

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complications which caused death.

(a) DUE TO: Coronary Occlusion — DURATION: 5 min.

(b) DUE TO:

(c):

ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS (Contributing to the death but not related to disease or condition causing it)

Every item must be carefully filled in. Physicians should enter only one cause per line for (a), (b), and (c). Exact statement of occupation is very important.

22. DATE OF OPERATION:
22a. MAJOR FINDINGS OF OPERATION:
23. AUTOPSY: Yes ☐ No ☒
24a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
24b. PLACE OF INJURY (In home, farm, factory, street, etc.):
24c. CITY OR TOWN / COUNTY / STATE:
24d. TIME OF INJURY (Month, day, year) (hour) .....m:
24e. INJURY OCCURRED: While at work ☐ Not at work ☐
24f. HOW DID INJURY OCCUR?

[conducted a post-mortem examination on the body of the decedent]

25. I hereby certify that I [attended the deceased from Dead on Arrival 19....., to .....19....., that I last saw deceased alive] on.....19..... and that death occurred at 6:35 p.m. from the cause and on the date stated above.

26a. SIGNATURE (Degree or Title): John R. Ford M.D.
26b. ADDRESS: Brattleboro, Vt.
26c. DATE SIGNED: 11-23-67

27a. BURIAL, CREMATION, REMOVAL (Specify): Burial
27b. DATE: Nov 26, 1967
27c. NAME OF CEMETERY OR CREMATORY: Rural Cemetery
27d. LOCATION (Town or County) (State): Southboro, Mass.

28. DATE REC'D BY TOWN OR CITY CLERK: Nov. 24 1967
29. CLERK'S SIGNATURE: Hettie B. Tupper
30. FUNERAL DIRECTOR'S SIGNATURE: Richard G. Caldwell
ADDRESS: 133 Main St Westboro Mass

Received December 11, 1967

31

2861
FORM R-301

To be issued by local permit issuing Board of Health or Agent

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WORCESTER
(City or Town making this return)

Registered No. 2937

PLACE OF DEATH
1 Worcester (County)
Worcester (City or Town)
No. Worcester City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ethel L. (Hoadley) Wheeler
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. Prentiss St. Southboro, Mass.
(City or town and State)

Length of stay In place of death years months 26 days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 30 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from 11/4/67 to 11/30/67, 19..
I last saw her alive on 11/30/67, 19.., death is said to have occurred on the date stated above, at 4:20AM m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial infarction — minutes
Due To
(b) Arteriosclerotic heart disease — years
Due To
(c)
OTHER SIGNIFICANT CONDITIONS Aortic stenosis — years; Multiple cardiac arrhythmia — weeks

Was autopsy performed? no
What test confirmed diagnosis? E.K.G., xray chest, laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Jerome L. Fielding, M.D.
(Address) 340 Main St. (Print or Type Name) Date 11/30/67

6 Rural Cemetery Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 2, 1967
7 NAME OF FUNERAL DIRECTOR Ronald E. Johnson
ADDRESS 129 Lincoln Street Worc.

Received and filed DEC 5 1967

A TRUE COPY ATTEST: Robert J. O'Keefe (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Female	White	Widowed

11 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Howard P. Wheeler (Give maiden name of wife in full) (Husband's name in full)

12 AGE 87 Years 6 Months 17 Days — If under 24 hours: Hours Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. 022-40-1707

16 BIRTHPLACE (City) (State or country) Wentville New York

PARENTS

17 NAME OF FATHER Charles Hoadley

18 BIRTHPLACE OF FATHER (City) (State or country) Not Learned

19 MAIDEN NAME OF MOTHER Ida (Hines)

20 BIRTHPLACE OF MOTHER (City) (State or country) Not Learned

21 Informant Mr. Clifford W. Wheeler
(Address) 127 Sachem Ave. Worcester

I HEREBY CERTIFY, That a supplemental standard certificate of death was filed with me BEFORE the burial or removal permit was issued.

(Signature of Agent of Board of Health or Town)
Commissioner of Public Health
(Official Designation) (Date of Issue of Permit)

ived
31, 1968
nara L. Burke
Inc

1 R-303

for burial permit
oard of Health
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-93638

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH: Worcester (County) / Worcester (City or Town)

Worcester (City or Town making this return)

Registered No. 2355

No. City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward Bugley
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. 8 Ward St. Southboro Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Dec (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

fracture of skull
& brain injury

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury Nov 1967

IF ACCIDENTAL, was injury causally related to the death? yes

Where did Injury occur? Southboro Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Rte 9 - White Cross (Specify type of place)

Manner of Injury fell out of window (How did injury occur?)

Nature of Injury fracture of skull - brain injury

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) [signature] M. D.

John C Ward (Print or Type Name)

(Address) 978 Main Date Dec 1 1967

7 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Dec. 1 1967

8 NAME OF FUNERAL DIRECTOR Donald F. Morris

ADDRESS Southboro, Mass.

DEC 6 1967

Received and filed ..... 19.....

A TRUE COPY, ATTEST: Robert J. O'Kane (Registrar)

Received January 18, 1968

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
M	White	married

12 If married, widowed, or divorced per und.
HUSBAND of Josephine Pleshaw
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE 60 Years ..... Months ..... Days | If under 24 hours: ..... Hours ..... Minutes

14 Usual Occupation: Custodian & Orderly
(Kind of work done during most of working life)

15 Industry or Business: Schools & Hospital

16 Social Security No. 010-03-0937

17 BIRTHPLACE (City) (Amherst)
(State or country) N.S. (Canada)

PARENTS

18 NAME OF FATHER Renwick Bugley

19 BIRTHPLACE OF FATHER (City) (Amherst)
(State or country) N.S. (Canada)

20 MAIDEN NAME OF MOTHER Minnie Brownell

21 BIRTHPLACE OF MOTHER (City) (Baie Vert)
(State or country) N.S. (Canada)

22 Informant Wayne Bugley
(Address)
8 Ward Rd. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature]
(Signature of Agent of Board of Health or other)

Charles M. Callahan
(Official Designation) (Date of Issue of Permit) Dec 5 1967

GRC

MEDICAL

2

.2854

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 34, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

1008-9-63-936368

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WORCESTER (City or Town making this return)

Registered No. 2955

1 PLACE OF DEATH: Worcester (County); Worcester (City or Town)

No. City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward Burley (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN – IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 8 Ward St. Southboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ____ years ____ months ____ days. In place of residence ____ years ____ months ____ days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Dec (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

fracture of skull & brain injury accident

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury 11/1 1967

IF ACCIDENTAL, was injury causally related to the death? yes

Where did Injury occur? Southboro Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Rte 9 - Within corner (Specify type of place)

Manner of Injury fr auto collision at intersection (How did injury occur?)

Nature of Injury fractures of skull - brain injury

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Jean C Ward M. D.

(Address) 978 Main Date Dec 1 1967

7 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Dec. 4 1967

8 NAME OF FUNERAL DIRECTOR Donald F. Harris

ADDRESS 40 Main St. Southboro Mass.

Received DEC 6 1967

Robert J. O'Keefe

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M

10 COLOR: White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): ~~married~~ widowed per und.

12 If married, widowed, or divorced HUSBAND of Josephine Pleshaw (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 60 Years ____ Months ____ Days If under 24 hours ____ Hours ____ Minutes

14 Usual Occupation: Custodian Orderly (Kind of work done during most of working life)

15 Industry or Business: Schools & Hospital

16 Social Security No. 10-0-037

17 BIRTHPLACE (City or Town) (Amherst) (State or Country) U.S. (Canada)

PARENTS

18 NAME OF FATHER Fredrick Burley

19 BIRTHPLACE OF FATHER (City) (Amherst) (State or country) U.S. (Canada)

20 MAIDEN NAME OF MOTHER Minnie Brownell

21 BIRTHPLACE OF MOTHER (City) (Baie Vert) (State or country) U.S. (Canada)

22 Informant Jayne Burley (Address) 8 Ward Rd. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Funeral Director with or without Seal)

Charles M. Callahan (Official Designation) (Date of Issue of Permit)

RECEIVED

23 Legal 18, 68 Mc

FORM R-305

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

PREPARED FOR BINDING

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough
(City or Town making this return)

Registered No. 306

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Cecil L. Vail
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence No. 58 Pinehill Road St. Southborough, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death D.O.A. years months days. In place of residence 2 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 1, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
coronary heart disease

5 Accident, suicide, or homicide (specify) no
Date and hour of injury 19
IF ACCIDENTAL, was injury causally related to the death?
Where did Injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury (How did injury occur?)
Nature of Injury
While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Kenneth R. Greenleaf, M. D.
(Address) Sudbury, Mass. Date Dec. 1 67

7 Whites Cove, Whites Cove, N.B.
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL December 5 67

8 NAME OF FUNERAL DIRECTOR Dykman Funeral Home
ADDRESS Jemsag, New Brunswick

Received and filed December 28, 67
Theresa F. Burke
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Male	White	Widowed

12 If married, widowed, or divorced
HUSBAND of Viola M. Ferris
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

13 AGE 60 Years 2 Months 10 Days | If under 24 hours Hours Minutes

14 Usual Occupation: Animal Technician
(Kind of work done during most of working life)

15 Industry or Business: Harvard Research

16 Social Security No. 020-40-1134

17 BIRTHPLACE (City) (State or country) Jemsag, New Brunswick, Ca

PARENTS

18 NAME OF FATHER Edward Vail

19 BIRTHPLACE OF FATHER (City) Jemsag
(State or country) New Brunswick, Canada

20 MAIDEN NAME OF MOTHER Frances Parks

21 BIRTHPLACE OF MOTHER (City) Youngs Cove
(State or country) New Brunswick, Canada

22 Informant (Address) Robert Vail - son
58 Pinehill Rd. Southboro, Mass.

A TRUE COPY
ATTEST: Peter P. Cottone
(Registrar of City or Town where death occurred)
Agent
DATE FILED Dec. 2, 1967 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bridget Farricy (Kenney) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Permanent Residence. No. 217 Southville Rd., St. Southboro, Mass. (City or town and State)

Length of stay: In place of death.....years.....months 14 days. In place of residence 5 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 16 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 12 1967, to December 16 67

I last saw her alive on December 15, 1967, death is said to have occurred on the date stated above, at 6:13am m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral thrombosis — 2 dys.

Due To (b) Arteriosclerosis — yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no If so, specify .....

(Signature) Timothy P. Stone, M. D.

(Address) Southboro Date 12/16 67

6 Place of Burial or Cremation: St. Patrick's Natick, Mass. (City or Town)

DATE OF BURIAL December 19 67

7 NAME OF FUNERAL DIRECTOR John Everett & Sons

ADDRESS Natick, Mass.

Received and filed January 8 1968

Eleanor T Burke

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)
female	white	widow

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James P. Farricy
(Husband's name in full)

12 AGE 93 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business at home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER Patrick Kenney

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Bridget Dorgan

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant John Farricy

(Address) 217 Southville Rd., Southboro, Mass.

A TRUE COPY

ATTEST: Michael J. Ward

(Registrar of City or Town where death occurred)

DATE FILED December 19 67